CAPITAL & COAST DISTRICT HEALTH BOARD

Health System Committee

Public Agenda

13 MARCH 2019

Board Room, Level 11, Grace Neill Block, Wellington Regional Hospital
9am to Midday

	ITEM	ACTION	PRESENTER	MIN	TIME	PG
1 PROCEDURAL BUSINESS					9am	
1.1	Karakia					
1.2	Apologies	**Records**	F Wilde			
1.3	Continuous Disclosure – Interest Register	**Accepts**	F Wilde			2
1.4	Confirmation of Draft Minutes 13 February 2019	**Approves**	F Wilde			5
1.5	Matters Arising	**Notes**	F Wilde			
1.6	Action List	**Notes**	F Wilde			12
1.7	Annual Work Programme	**Approves**	R Haggerty			14
2 PRESENTATION						
2.1	3DHB Falls and Fracture Prevention Project	**Notes**	K Greer			15
3 DECISION						
3.1	Draft Annual Plan 3.1.1 CCDHB 2019/20 Annual Plan: First Draft	**Endorses**	R Haggerty			32 36
3.2	Pro-Equity 3.2.1 Pro-Equity Check Up Report December 2018 3.2.2 Māori and Pasifika Leaders Experience of Government Health Advisory Groups in New Zealand	**Agrees**	R Haggerty			124 127 172
4 DISCUSSION						
4.1	Annual Budget and Service Proposal Update 4.1.1 Health System Committee Priorities	**Notes**	R Haggerty			183 187
4.2	System Innovation and Performance Update	**Notes**	R Haggerty			199
4.3	Hospital and Health Services Update	**Notes**	C Virtue/D Hunter			205
4.4	Update on Flu and Measles in CCDHB	**Notes**	R Haggerty			217

DATE OF NEXT MEETING 17 APRIL – LEVEL 11, BOARD ROOM GRACE NEILL BLOCK WELLINGTON REGIONAL HOSPITAL

HEALTH SYSTEM COMMITTEE

Interest Register

UPDATED AS AT FEBRUARY 2019

Name	Interest
Dame Fran Wilde *Chairperson*	• Ambassador Cancer Society Hope Fellowship • Chief Crown Negotiator Ngati Mutunga and Moriori Treaty of Waitangi Claims • Chair, Remuneration Authority • Chair Wellington Lifelines Group • Chair National Military Heritage Trust • Deputy Chair, Capital & Coast District Health Board • Director Museum of NZ Te Papa Tongarewa • Director Frequency Projects Ltd • Chair, Kiwi Can Do Ltd
Mr Andrew Blair *Member*	• Chair, Capital & Coast District Health Board • Chair, Hutt Valley District Health Board • Chair, Hutt Valley DHB Hospital Advisory Committee • Chair, Queenstown Lakes Community Housing Trust • Member, State Services Commission Advisory Group on Crown Entity Chief Executive Remuneration • Member of the Governing Board for the Health Finance, Procurement and Information Management System business case • Member, Hutt Valley DHB combined Disability Support Advisory Committee • Member, Hutt Valley DHB Community and Public Health Advisory Committee • Member, Capital & Coast DHB Finance, Risk and Audit Committee • Member, Capital & Coast Health Systems Committee • Owner and Director of Andrew Blair Consulting Limited, a Company which from time to time provides governance and advisory services to various businesses and organisations, include those in the health sector • Former Member of the Hawkes Bay District Health Board (2013-2016) • Former Chair, Cancer Control (2014-2015) • Former CEO Acurity Health Group Limited • Advisor to Southern Cross Hospitals Limited and Central Lakes Trust to establish an independent short stay surgical hospital in the Queenstown Lakes region • Advisor to the Board of Breastscreen Auckland Limited • Advisor to the Board of St Marks Women's Health (Remuera) Limited
Mr Andrew Blair *Member*	• Chair, Capital & Coast District Health Board • Chair, Hutt Valley District Health Board (from 5 December 2016) • Chair, Queenstown Lakes Community Housing Trust • Member, State Services Commission Advisory Group on Crown Entity Chief Executive Remuneration • Advisor to the Board, Forte Health Limited, Christchurch • Owner and Director of Andrew Blair Consulting Limited, a Company which from

Name	Interest
	time to time provides governance and advisory services to various businesses and organisations, include those in the health sector • Former Member of the Hawkes Bay District Health Board (2013-2016) • Former Chair, Cancer Control (2014-2015) • Former CEO Acurity Health Group Limited • Advisor to Southern Cross Hospitals Limited and Central Lakes Trust to establish an independent short stay surgical hospital in the Queenstown Lakes region • Advisor to the Board of Breastscreen Auckland Limited • Advisor to the Board of St Marks Women's Health (Remuera) Limited
Ms Sue Kedgley *Member*	• Member, Capital & Coast District Health Board • Member, CCDHB CPHAC/DSAC • Member, Greater Wellington Regional Council • Member, Consumer New Zealand Board • Deputy Chair, Consumer New Zealand • Environment spokesperson and Chair of Environment committee, Wellington Regional Council • Step son works in middle management of Fletcher Steel
Dr Roger Blakeley *Member*	• Member of Capital and Coast District Health Board • Deputy Chair, Wellington Regional Strategy Committee • Councillor, Greater Wellington Regional Council • Director, Port Investments Ltd • Director, Greater Wellington Rail Ltd • Economic Development and Infrastructure Portfolio Lead, Greater Wellington Regional Council • Member, Harkness Fellowships Trust Board • Independent Consultant • Brother-in-law is a medical doctor (anaesthetist), and niece is a medical doctor, both working in the health sector in Auckland • Son is Deputy Chief Executive (insights and Investment) of Ministry of Social Development, Wellington • Member of the Wesley Community Action Board • Member of the Regional Steering Group, Warm Healthy Homes
Ms 'Ana Coffey *Member*	• Member of Capital & Coast District Health Board • Councillor, Porirua City Council • Director, Dunstan Lake District Limited • Trustee, Whitireia Foundation • Brother is Team Coach for Pathways and Real Youth Counties Manukau District Health Board • Father is Acting Director in the Office for Disability Issues, Ministry of Social Development

Name	Interest
Ms Eileen Brown *Member*	• Member of Capital & Coast District Health Board • Board member (until Feb. 2017), Newtown Union Health Service Board • Employee of New Zealand Council of Trade Unions • Senior Policy Analyst at the Council of Trade Unions (CTU). CTU affiliated members include NZNO, PSA, E tū, ASMS, MERAS and First Union • Executive Committee Member of Healthcare Aotearoa • Nephew on temporary CCDHB ICT employment contract
Ms Sue Driver *Member*	• Community representative, Australian and NZ College of Anaesthetists • Board Member of Kaibosh • Daughter, Policy Advisor, College of Physicians • Former Chair, Robinson Seismic (Base isolators, Wgtn Hospital) • Advisor to various NGOs
Mr Fa'amatuainu Tino Pereira *Member*	• Managing Director Niu Vision Group Ltd (NVG) • Chair 3DHB Sub-Regional Pacific Strategic Health Group (SPSHG) • Chair Pacific Business Trust • Chair Pacific Advisory Group (PAG) MSD • Chair Central Pacific Group (CPC) • Chair, Pasefika Healthy Home Trust • Establishment Chair Council of Pacific Collectives • Chair, Pacific Panel for Vulnerable Children • Member, 3DHB CPHAC/DSAC
Dr Tristram Ingham *Member*	• Senior Research Fellow, University of Otago Wellington • Member, Capital & Coast DHB Māori Partnership Board • Member, Scientific Advisory Board – Asthma Foundation of NZ • Chair, Te Ao Mārama Māori Disability Advisory Group • Councillor at Large – National Council of the Muscular Dystrophy Association • Member, Executive Committee Wellington Branch MDA NZ, Inc. • Trustee, Neuromuscular Research Foundation Trust • Member, Wellington City Council Accessibility Advisory Group • Member, 3DHB Sub-Regional Disability Advisory Group • Professional Member – Royal Society of New Zealand • Member, Institute of Directors • Member, Health Research Council College of Experts • Member, European Respiratory Society • Member, Te Ohu Rata o Aotearoa (Māori Medical Practitioners Association) • Director, Miramar Enterprises Limited (Property Investment Company) • Wife, Research Fellow, University of Otago Wellington

CAPITAL AND COAST DISTRICT HEALTH BOARD
DRAFT Minutes of the Health System Committee
Held on Wednesday 13 February 2019 at 9am
Board Room, Level 11, Grace Neill Block, Wellington Regional Hospital

PUBLIC SECTION

PRESENT

BOARD:	Dame Fran Wilde (Chair) Ms Sue Kedgley Dr Roger Blakeley Ms Eileen Brown Ms Ana Coffey (arrived 9.20am) Ms Sue Driver Ms Sue Emirali Mr Tino Fa'amatuainu Pereira (left 11.15am) Dr Tristram Ingham
STAFF:	Ms Rachel Haggerty, Director, Strategy Innovation and Performance Ms Emma Hickson, Acting Executive Director, Nursing and Midwifery Mrs Arawhetu Gray, Director Māori Health Mrs Robyn Fitzgerald, Committee Secretary Ms Rachel Pearce, Senior System Development Manager Mr Thomas Davis, General Manager, Corporate Services (arrived 9.37am) Mr Anthony Boardman, Senior Accountant Ms Wendy Page, Business Support Manager Ms Taima Fagaloa, Director Pacific People Health Dr James Entwistle, Executive Clinical Director Ms Julie Patterson, Interim CEO, CCDHB (arrived Mr Peter Guthrie, Manager Planning and Performance Ms Jenny Langton, Principal Advisor
PRESENTERS:	Mr Martin Hefford, CEO Tu Ora Compass Health (Items 2.1, 3.1) (arrived 9.26am) Ms Taima Fagaloa, Director Pacific Health (Item 2.2) Mr Taulalo Fiso, Director Community Partnership, Strategy Innovation and Performance (Item 2.4) Ms Carey Virtue, Executive Director, Operations Medicine Cancer & Community (Item 3.2)
GENERAL PUBLIC:	One member of the public arrived at the meeting at 9.00am.

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1 PROCEDURAL BUSINESS

1.1 PROCEDURAL

The Karakia was led by Tristram Ingham. Committee Chair, Dame Fran Wilde, welcomed members of the public and DHB staff.

1.2 APOLOGIES

Apologies received from Andrew Blair. Julie Patterson sent her apologies and notice that she will be arriving late.

1.3 INTERESTS

1.3.1 Interest Register

No changes received.

1.4 CONFIRMATION OF PREVIOUS MINUTES

The minutes of the CCDHB Health System Committee held on 28 November 2018, taken with public present, were confirmed as a true and correct record.

It was **noted** that the Chair, Director of SIP and Committee Secretary will review the recording of main issues that are discussed in committee.

Moved: Sue Kedgley **Seconded:** Eileen Brown **CARRIED**

1.5 MATTERS ARISING

1.6 ACTION LIST

The reporting timeframes on the other open action items were **noted**.

The Committee**:**

(a) **Noted** that collaboration is currently underway between the Regional Public Health Service and the Systems Innovation and Performance Directorate of CCDHB on the liquor licensing impacts hospital admissions in the Porirua community and other local issues;

(b) **Noted** that the Bowel screening programme for Capital and Coast District Health Board region has been delayed until March 2020.

Action:

1. Management to provide an update at the next HSC meeting on the Bowel screening programme and addressing equity issues.

Note the agenda items are presented in the order that the Committee considered them.

2 DECISION

2.3 Primary Birthing Facility Feasibility Review

The paper was taken as **read**.

The Committee:

(a) **Noted** the final Primary Birthing Unit Consultation report and recommendations;

(b) **Noted** the widespread community and provider support for a third CCDHB primary birthing facility, located in close proximity to Wellington Regional Hospital;

(c) **Welcomed** the fact that a feasibility study of a potential Wellington Primary birthing facility has been commissioned to commence in March 2019, reporting to the Board with recommendations in July 2019;

(d) **Noted** that feasibility report will include an analysis of the total impact of the service using a "total wellbeing" perspective. This includes and is not limited to opportunities for alternatives of care; early day care; who is giving birth and where; trends analysis and changing of

demographics; equity impact of service; economic analysis; mothers who have challenges such as teen pregnancy and/or relationship issues; mental health issues; gaps now and in the future; cost benefit analysis and workforce issues. The study will also provide the board with timelines; the parameter of costs, delivery and outcomes. A decision to proceed with such a unit would need to be made in the context of all other competing activities that require additional funding.

(e) **Noted** that co-designing has not commenced until feasibility study report has been accepted by Board;

(f) **Noted** that Consumer Group is to include Pacific and Māori membership.

HSC recommends the Board:

(a) **Note** the paper.

Action:

2. Management to provide an update to HSC of the role of the midwives in a birthing unit.

Moved:	Tristram Ingham	**Seconded:**	Ana Coffey	**CARRIED**

3 DISCUSSION

3.1 Access to Psychological Therapies for 18 to 25 year olds

The paper was taken as **read**.

The Committee:

(a) **Noted** that attached reports outlined the opportunity secured by Tū Ora to deliver more therapy services to young people (18-25) with mild-moderate mental health conditions;

(b) **Noted** that CCDHB and HVDHB are working closely with Tū Ora to ensure an integrated service model in our communities;

(c) **Noted** that the model uses an app developed by Melon that can be used on any device, and is supported by counsellors;

(d) **Noted** that a comprehensive evaluation is included in the programme;

(e) **Noted** that the programme is funded by the Ministry of Health;

(f) **Noted** that the service should be fit for purpose and inclusive of equity view and participation;

(g) **Noted** that CCDHB will be included in Governance and programme development;

(h) **Noted** that should the pilot trial programme be successful then consideration will need to be given to funding support by CCDHB at the end of the three year contract;

(i) **Noted** that critical to the success of this programme are measurable outcomes.

2 DECISION

2.1 Porirua Children's Skin Project

The paper was taken as **read**.

The Committee:

(a) **Noted** that Tū Ora Compass Health has undertaken a children's skin project in the Porirua area;

(b) **Noted** the details of the project and its findings, outlined in the attached report;

(c) **Noted** the strategic opportunity for both CCDHB and PHOs to strengthen the engagement with Early Childhood Centres (ECEs) and COLs as part of a wider Porirua Locality approach, leading to improved outcomes for children living in Porirua;

(d) **Agreed** that this work falls within the CCDHB Porirua Locality plan to improve the outcomes for children, young people and their family/whānau and should be progressed as a priority;

(e) **Noted** that the next step is to develop a relationship with local Communities of Learning (COLs) to better understand the challenges that schools face;

(f) **Agreed** to collectively explore advocacy options to address issues identified as part of the work with schools noted in (e) above.

HSC recommends the Board:

1. **Note** the paper.

Action:

3. Management to bring back to the committee information regarding the schools that did not have hot water for students, in order to ascertain reasons. Depending on responses and reasons, HSC might consider taking the matter further with the appropriate minister (Hon Jenny Salesa), noting the fundamental importance of services such as hot water supply and resources such as soap and hand drying facilities.

2.2 Pacific Nurse-led Neighbourhood Service in Porirua

The paper was taken as **read**.

The Committee:

(a) **Noted** that CCDHB are prioritising the development of our localities;

(b) **Noted** and applauded the programme as a great example focussed on equity, culturally appropriate and a community approach;

(c) **Noted** that this engaged service will be funded for 3 years;

(d) **Noted** that outcome measures to recognise the holistic outcomes that can be achieved in both short and long term timeframes;

(e) **Noted** the impact of the workforce and the need for cultural training and the inclusion of family networks in this programme.

Action:

4. Management to provide a communique upon the launch of this programme – as an example of the delivery of services in the most culturally appropriate way, enabling local people to take control.

Moved: Roger Blakeley **Seconded**: Tristram Ingham **CARRIED**

2.4 Citizens Health Council (The Council) Update and Approach

The paper was taken as **read**.

The Committee:

(a) **Noted** that the Citizens Health Council Terms of Reference has been ratified and committee membership confirmed;

(b) **Endorsed** the public messaging developed at the Citizens Health Council meeting on 30 January 2019;

(c) **Noted** that part of the Localities programme engagement is made with networks whereas the Citizens Council engages with individuals;

(d) **Noted** that some members of the Citizens Council have indicated that their main purpose of membership is to develop links both with the community and internally;

(e) **Noted** that the evaluation should connect with communities (one example being people who use traditional Chinese practitioners), should enable disparate groups to attend meetings, and make use of different communication platforms

Actions:

5. SIP to provide advice about membership of Citizens' Council member representation on HSC;
6. SIP to report back in May with Terms of Reference.

Moved: Sue Driver **Seconded:** Eileen Brown **CARRIED**

3 DISCUSSION

3.2 Cancer Services Review

The paper was taken as **read**.

The Committee:

(a) **Noted** that the progress of the Cancer Services Review and the commitment to a service improvement programme;

(b) **Noted** that recruitment has commenced to the position of clinical director to lead the development of this programme;

(c) **Noted** this work is intended to complement and support the Central Regional DHB's work designing the future direction and organising structure for cancer services in the Central Region;

(d) **Noted** the variation of service quality of care; access of care and services nationally.

Actions:

7. Management to send out radio link to HSC members re cancer drugs (12 February 2019);
8. Management to provide an update on what is happening locally, regionally and nationally and to also include addressing cancer outcomes by population group.

4 INFORMATION

4.1 LOCALITIES DIAGRAM

The paper was taken as **read**.

The Committee:

(a) **Endorsed** and adopted the Localities diagram which had been developed from the November Committee discussions;

(b) **Noted** that the papers presented at the HSC meeting link very clearly with the strategies of the Health System Committee.

HSC recommends to the Board:

(a) That all Board papers should have a tick box confirming linkages to key strategies.

Actions:

9. Management to invite other Board members to HSC meetings and to view papers presented at HSC meetings;
10. HSC papers to have a check list of strategies with a tick box on the covering page of papers.

Moved: Roger Blakeley **Seconded:** Sue Kedgley **CARRIED**

5 OTHER

5.1 RESOLUTION TO EXCLUDE THE PUBLIC

RECOMMENDATION

The Health System Committee **noted** and **resolved** to:

(a) **Agree** that as provided by Clause 32(a), of Schedule 3 of the New Zealand Public Health and Disability Act 2000, the public are excluded from the meeting for the following reasons:

SUBJECT	REASON	REFERENCE
Older People Services — Risk on Aged Residential Care beds	Papers contain information and advice that is likely to prejudice or disadvantage commercial activities and/or disadvantage negotiations	9(2)(b)(i)(j)

Moved: Roger Blakeley **Seconded:** Fran Wilde **CARRIED**

*Meeting closed at 11.45am***.**

6 DATE OF NEXT MEETING

13 March 2019, 9am, Board Room, Level 11, Grace Neill Block, Wellington Regional Hospital.

CONFIRMED that these minutes constitute a true and correct record of the proceedings of the meeting

DATED this .....day of.....2019

Fran Wilde
Health System Committee Chair

DRAFT

Capital & Coast District Health Board
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SCHEDULE OF ACTION POINTS – HEALTH SYSTEM COMMITTEE (HSC)

AP No:	Item No.	Topic	Action:	Responsible:	How Dealt With:	Delivery Date:
HSC Public Meeting 13 February 2019						
P001	**1.6**	**Action List**	Management to provide an update at the next HSC meeting on the Bowel screening programme and addressing equity issues.	Dir Sip/Exec Dir Ops & MCC	Report	Mar
P002	**2.3**	**Primary Birthing Facility Feasibility Review**	Management to provide an update to HSC of the role of the midwives in a birthing unit.	Dir Sip	Report	July
P003	**2.1**	**Porirua Children's Skin Project**	Management to bring back to the committee information regarding the schools that did not have hot water for students, in order to ascertain reasons. Depending on responses and reasons, HSC might consider taking the matter further with the appropriate minister (Hon Jenny Salesa), noting the fundamental importance of services such as hot water supply and resources such as soap and hand drying facilities.	Dir Sip	Paper	Apr
P004	**2.2**	**Pacific Nurse-led Neighbourhood Service in Porirua**	Management to provide a communique upon the launch of this programme – as an example of the delivery of services in the most culturally appropriate way, enabling local people to take control.	Dir Sip/Coms	Media release	Mar
P005	**2.4**	**Citizens Health Council**	Management to provide advice about membership of Citizen's Council member representation on HSC.	Dir Sip	Advice	Apr
P008	**3.2**	**Cancer Services Review**	Management to provide an update on what is happening locally, regionally and nationally and to also include addressing cancer outcomes by population group.	Exec Dir Operations and MCC	Paper	March

Closed since last meeting – 13 March 2019

AP No:	Item No.	Topic	Action:	Responsible:	How Dealt With:	Delivery Date:
HSC Public Meeting 13 February 2019						
P006	**2.4**	**Citizens Health Council**	Management to report back with Terms of Reference.	Dir SIP	TOR made available	February
P007	**3.2**	**Cancer Services Review**	Management to send out radio link to HSC members re cancer drugs item (12 February 2019)	Comms/Secretary	Email	February
P009	**4.1**	**Localities Diagram**	Management to invite other Board members to HSC meetings and to view papers presented at HSC meetings	Chair and Dir SIP	Talk to other Board members	March
P010	**4.1**	**Localities Diagram**	Management to develop a checklist for all HSC papers to identify strategies covered in papers	Dir SIP	Develop checklist	March

Draft Health System Committee Workplan 2019

Regular HSC items: (Public) HSC Report and Minutes; Resolution to Exclude (Public Excluded):

Month		13 February	13 March	17 April	15 May	12 June	17 July	14 August	11 September	16 October	13 November
Location		CCDHB	CCDHB	CCDHB	CCDHB	CCDHB	CCDHB	CCDHB	Porirua	Kenepuru	Paraparaumu
Strategy and Planning	**DECISION**	Porirua Children's Skin Project Pacific Nurse-led Neighbourhood Service in Porirua Primary Birthing Facility Feasibility Review Citizens Health Council Update	Draft Annual Planning Investment and Prioritisation Update Pro-Equity	Even Better Health Care Plan 17/20 Māori Health Strategy Investment and Prioritisation Update Citizens Health Council Update	Draft Regional Services Plan NZHPL Accountability Final Draft Annual Plan 2019/20 Investment and Prioritisation Update	Māori Health Action Plan Investment and Prioritisation Update Citizens Health Council Update	Final LTIP Investment and Prioritisation Update	2020 Joint Board Schedule and workplan Final Draft Regional Services Plan 2019/20 Final Annual Plan and Capital Budget 2019/20 Investment and Prioritisation Update Citizens Health Council Update	Draft Financials Annual Report Investment and Prioritisation Update	Final Annual Report 2018/19 Draft Annual Plan 2019/20 Investment and Prioritisation Update Citizens Health Council Update	Investment and Prioritisation Update
	DISCUSSION			Even Better Health Care Plan Update	Progress update – Regional Services 18/19	Prioritisation and Investment Update for implementing the Health System Plan				Investment Plan Update	Progress update – Regional Services 18/19
Regular Reporting	**DISCUSSION**	Access to Psychological therapies for 18 to 25 year olds Cancer Services Review Localities Diagram	System Innovation and Performance Update Hospital and Health Services Update	Quarter 2 Performance Report 3DHB MHAIDS update 3DHB ICT Update 3DHB DSAC Report	Hospital Network Planning System Innovation and Performance Update Hospital and Health Services Update	Quarter 3 Performance Report	System Innovation and Performance Update Hospital and Health Services Update 3DHB MHAIDS update 3DHB ICT Update 3DHB DSAC Report	Hospital Network Planning	Quarter 4 Performance Report System Innovation and Performance Update Hospital and Health Services Update	3DHB MHAIDS update 3DHB ICT Update 3DHB DSAC Report	Hospital Network Planning System Innovation and Performance Update Hospital and Health Services Update
	INFORMATION	Population Health (Regional Public Health Report)		Pacific Health Update Māori Health Update Bowel Screening Rebal Service Development			Pacific Health Update Māori Health Update	Population Health (Regional Public Health Report)		Pacific Health Update Māori Health Update	

V1

3 DHB Community Falls and Fracture Prevention Program

Wairarapa DHB
Wairarapa District Health Board
Te Poari Hauora a-rohe o Wairarapa

HUTT VALLEY DHB

Capital & Coast
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Development History

- 2015 HSQC Release Community Falls Prevention Toolkit for Clinicians

- 2017 3DHB workstream develop combined preventative model of care.

- 2019 3DHB implementation of community falls and fracture prevention model partnered with ACC Funding.

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Te Poari Hauora a-rohe o Wairarapa

HUTT VALLEY DHB

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Program Governance and Management

3DHB Falls Program Steering Group

PCAT

(Primary Care Alliance Trust)

Hosted at Tu Ora Compass Health Primary Network

Why do we need it ?

- CCDHB Pop > 65 41,000

- 1/3 Community dwelling people > 65 will fall at least once a year

- 1/2 >80 meet the same fate.

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Te Poari Hauora a-rohe o Wairarapa

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Consequences

- Fragility Fractures
- Personal
- Health System Cost

Fracture Consequences

- 4% will suffer a fragility #
- In CCDHB approx 500 fragility # annually
- 100 will be # neck of femur

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Te Poari Hauora a-rohe o Wairarapa

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Personal Consequences

- Pain
- Decreased mobility
- Loss of Independence
- Death.

Health System Expenditure Consequences

Health System Costs # Neck of Femur

- $50,000 Hospital admission and surgery cost only for each hip #
- 100 hip # CCDHB annually
- Annual CCDHB expenditure $5,000,000

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The Model

- Falls and Fracture preventative program currently being rolled out in our planned CCDHB Community Health Networks.

- HealthCare Home clinical teams are the foundation

Model Components

- Proactive Screening for Falls Risk in Older Enrolled Population
- Primary Care Business as Usual Falls Care
- Fragility Fracture Protocol

Proactive Screening in Health Care Homes

- All enrolled > 65 years Maori, Pacific
  > 75 years other ethnicity
- 3 Questions

- Strength and balance assessment

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Wairarapa District Health Board
Te Poari Hauora a-rohe o Wairarapa

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Primary Care Business as Usual Falls

- Patient with fall self presenting to Practice Team
- Family/Whanau fall concerns

- Ambulance fall referral
- Other Professional referrals

District Nursing

Allied Health

Home Support

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Wairarapa District Health Board
Te Poari Hauora a-rohe o Wairarapa

HUTT VALLEY DHB

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Fragility Fracture Protocol

- Data flow from hospital care to program management service hosted in Tu Ora Compass Health

- Health Care Home practices notified of enrolled fragility # patients

Clinical Assessment in Primary Care

- History
- Physical Examination
- Investigations if required

Management Plan

- Home Safety Check
- Medication Review
- Manage other causes
- Lower Limb Strength and Balance Programs

Community approved group exercise program

In home one on one physio supervised program

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3D HealthPathway Tools

- Falls Risk – Assessment and Reduction
- Medication Management and Polypharmacy in Older People
- Fragility Fracture

PUBLIC

Capital & Coast District Health Board ŪPOKO KI TE URU HAUORA	**HEALTH SYSTEM COMMITTEE DECISION**
	Date: 3 March 2019

Author	Peter Guthrie, Manager Planning & Performance Wikke Bargh-Koopmans, Senior Advisor Planning & Performance
Endorsed by	Rachel Haggerty, Director Strategy, Innovation and Performance
Subject	**FIRST DRAFT ANNUAL PLAN 2019/20 INCLUDING STATEMENT OF INTENT (SOI) AND STATEMENT OF PERFORMANCE EXPECTATIONS (SPE)**

RECOMMENDATIONS

It is **recommended** that the Health System Committee:

(a) **NOTES** the Minister of Health's Letter of Expectations, outlining Government priorities;

(b) **NOTES** that the Ministry of Health has provided the Annual Plan 2019/20 Guidance;

(c) **NOTES** that the proposed Service changes must be submitted to the Ministry of Health by 8 March;

(d) **NOTES** that the first draft Annual Plan 2019/20 will be presented at the March Board meeting;

(e) **APPROVES** the first draft Annual Plan 2018/19 for inclusion in the 28 March Board papers;

(f) **NOTES** that the first draft Annual Plan 2019/20 must be submitted to the Ministry of Health by 8 April;

(g) **DELEGATES AUTHORITY** to the Chief Executive to make any changes to the Annual Plan that ELT may require;

(h) **PROVIDES FEEDBACK** on the changes to the Annual Plan to Director, SIP by close of business Tuesday 12 March prior to presentation of the first draft Annual Plan to the Board.

APPENDIX

1. Capital & Coast District Health Board (CCDHB) 2019/20 Annual Plan: First Draft.

Health System Plan Outcomes		**Stewardship**	
Wellbeing Strengthen our communities, families and whānau so they can be well		**Quality & Safety** Quality & safety of service delivery	
People Centred Make it easier for people to manage their own health needs		**Service Performance** Report on service performance.	**X**
Equity Support equal health outcomes for all communities		**Health System Performance** Report on health system performance	**X**
Prevention Delay the onset, and reduce the duration and complexity, of long-term health conditions		**Planning Processes and Compliance** Planning processes and compliance with legislation or policy.	**X**
Specialist Services Ensure expert specialist services are available to help improve people's health		**Government Priority** Equity; Child Wellbeing; Mental Health; Primary Care; Water Safety	

PUBLIC

1. PURPOSE

This paper seeks feedback from the Health System Committee (HSC) on the first draft Annual Plan 2019/20 prior to presenting the draft Annual Plan to the Board on 28 March 2019. Development of the first draft Annual Plan 2019/20 has been coordinated by Strategy, Innovation and Performance (SIP), with substantive input from Directorates.

2. BACKGROUND

The Annual Plan template and requirements are supplied by the Ministry of Health. CCDHB ensures alignment between the Annual Plan template and the work programme of CCDHB. There remain a number of blank components in the Annual Plan as we are awaiting further advice from the Ministry of Health.

3. THE MINISTER OF HEALTH'S LETTER OF EXPECTATIONS FOR 2019/20

The Minister's Letter of Expectations outlines the Government's priorities for health to ensure that our public health system is:

- strong and equitable;
- performing well; and,
- focused on the right things to make all New Zealanders' lives better.

The priorities outlined in the Minister's Letter of Expectations for 2019/20 include:

a. Achieving Equity;
b. Strong and Equitable Public Health and Disability System;
c. Mental Health and Addiction Care;
d. Child Wellbeing;
e. Primary Health Care;
f. Non-Communicable Disease (NCD) Prevention and Management;
g. Public Health and the Environment; and,
h. Fiscal Responsibility.

4. DEVELOPMENT OF THE ANNUAL PLAN 2019/20

Each DHB has a statutory responsibility to prepare an Annual Plan for approval by the Minister of Health, providing accountability to the Minister of Health.

The short form Annual Plan template provided by the Ministry of Health consists of five sections:

4.1 Section 1: Overview of Strategic Priorities

This section of the Annual Plan outlines the Strategic Intentions and Priorities, articulating CCDHB's commitment to meeting the Minister of Health's expectations to implement the New Zealand Health Strategy, and continue the commitment to CCDHB's Strategic Vision.

This section includes a Foreword from the Board Chair and Chief Executive. In the draft Annual Plan, we have left a placeholder for the Forewords which will be developed at a later stage.

4.2 Section 2: Delivering on Priorities

This section outlines the 'Planning Priorities', which include the overarching Government priorities and DHB specific Planning Priorities. The Ministry's Annual Planning Guidance Document outlines the target areas. For 2019/20 these are:

- Strong and equitable public health and disability system;

- Mental health and addictions care;
- Child wellbeing;
- Primary health care; and,
- Environmental sustainability and drinking water safety

This section consists of 35 'Planning Priorities' across the five target areas. CCDHB's planned activities and milestones for 2019/20 are outlined against each of these planning priorities. A placeholder is currently in place for the following sections as DHBs are awaiting further guidance from the Ministry:

- Strategic Health Measures;
- Planned Care;
- Bowel Screening;
- Delivery of Regional Service Plan (RSP) priorities;
- Inquiry into mental health and addiction;
- Supporting Health in Schools; and,
- School-Based Health Services.

Section 2 also includes a summary of Financial Performance; a high level summary of expected financial performance for the 2019/20 year and out years. A placeholder is currently in place for the financial performance summary pending release of the Funding Envelope.

4.3 Section 3: Service Configuration

This section describes service reviews and service changes that have been approved or proposed for implementation in 2019/20. Information in this section includes service areas not covered in Section 2 and may relate to ongoing service improvement work of the DHB outside of the national Health Target areas.

4.4 Section 4: Stewardship

The Stewardship section describes the arrangements and systems the DHB has in place to manage our core functions and deliver planned services. This section will outline CCDHB's stewardship of its assets, workforce, ICT and other infrastructure. This section is divided into two parts: 'Managing our Business' and 'Building Capability'.

4.5 Section 5: Performance Measures

The Performance Measures section updates the Non-Financial Monitoring Framework and Performance Measures used to monitor DHB performance. Completion of data in this table will be updated for the end of the Quarter 3 reporting period and local targets will be set where appropriate for submission of the second draft.

4.6 Appendix A: Statement of Intent – 2019/20 to 2022/23

Each DHB has a statutory responsibility to prepare a Statement of Intent (SOI), providing accountability to Parliament and the public at least triennially. The SOI outlines the strategic direction for CCDHB over a three-year period. The Minister of Health has indicated that all DHBs will be required to develop an SOI for 2019/20. An initial outline and direction for the SOI has been included in this draft Annual Plan. The SOI will continue to be developed in time for submission of the second draft Annual Plan to the Ministry.

4.7 Appendix B: Statement of Performance Expectations

Each DHB has a statutory responsibility to prepare a Statement of Performance Expectations (SPE), providing performance and financial accountability to Parliament and the public annually.

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The SPE enables the Minister to participate in the process of setting annual performance expectations, to inform the House of Representatives and to provide a base against which annual performance can be assessed. The SPE will be audited by Audit NZ and CCDHB is required to report against the measures in the Annual Report.

For 2019/20 we have reviewed the performance measures in the SPE so that they reflect the priorities of the Government, the Ministry and CCDHB. This has also included an active attempt to shift indicators from a focus on Outputs (i.e. activity) to Outcomes (i.e. how well did we do it) and Impact (i.e. what difference did we make).

The SPE contains forecast financial statements for the forecast year prepared under generally accepted accounting practice. The forecast financial statements must include:

- a statement of all significant assumptions underlying the forecast financial statements; and,
- any additional information and explanations needed to fairly reflect the forecast financial operations and financial position of the DHB.

DHBs must submit to the Ministry financial templates supporting the Annual Plan that comply with monthly/quarterly financial reporting requirements. DHBs must provide all necessary information in the financial templates to meet Crown Financial Information Systems reporting requirements. A placeholder is currently in place for the Financial Performance section pending release of the Funding Envelope.

4.8 Appendix C: System Level Measures Improvement Plan

The System Level Measures (SLM) Framework aims to improve health outcomes for people by supporting DHBs to work in collaboration with health system partners (primary, community and hospital) using specific quality improvement measures. The SLM Framework provides a foundation for continuous quality improvement and system integration. A placeholder is currently in place for the SLM Improvement Plan pending development and approval of the Plan by the Integrated Care Collaborate. This is on target for completion,

5. NEXT STEPS

The timeline for the Annual Planning process for 2019/20 is:

Activity	Timeline/Date
Proposed Service Changes Submitted to MoH	8 March
HSC to Review Draft Annual Plan 2019/20	13 March
Board to Review and Endorse Draft Annual Plan 2019/20	28 March
First draft Annual Plan 2019/20 Submitted to MoH	5 April
Planning Priority Forums to Discuss Draft Annual Plan	5 April – 10 May
Draft Annual Plan 2019/20 Presented to the Māori Partnership Board, the Sub-Regional Pacific Health Advisory Group and the 3DHB Disability Support Advisory Committee	April – May
Board to Approve Final Draft Annual Plan 2019/20	30 May
CFO to Provide the Financial Performance Sections to SIP	By 20 June
Final Draft Plan Submitted to MoH	21 June

Capital & Coast District Health Board
ŪPOKO KI TE URU HAUORA

CCDHB Annual Plan 2019/20

Incorporating the Statement of Intent and Statement of Performance Expectations

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Annual Plan dated *xx June 2019*

(Issued under Section 39 of the New Zealand Public Health and Disability Act 2000)

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SECTION ONE: Overview of Strategic Priorities

1.1 Strategic Intentions/Priorities

This Annual Plan articulates Capital and Coast District Health Board's (CCDHB) commitment to meeting the Minister of Health's expectations and continue the commitment to deliver CCDHBs vision of:

"Keeping our Community Healthy and Well."

To deliver on this vision, CCDHB is developing and implementing a health system that organises service delivery in the most appropriate setting, for our people and communities that makes the best use of resources to achieve positive health outcomes and ***equity*** amongst our population. It recognises the role of many in our success; our communities, our families, our workforce, our provider partners, our Ministry and our social service partners. At the heart of this approach is enabling people and their whānau to take the lead in their own health and wellbeing.

The Capital and Coast Health System Plan 2030 (HSP2030) outlines our strategy to improve the performance of our healthcare system to support people to have better health and wellbeing throughout their lives and ensure equity amongst our communities. The plan will enable us to respond to the growing demand for healthcare, and increasing complexity with a system design that will improve outcomes and equity for the people of the Capital and Coast district, and the wider central region. The Health System Plan I supported by this whakatauki:

"Ma Tini, Ma Mano, Ka Rapa, Te Whai

By Joining Together We Will Succeed"

To achieve our obligations to the Minister, the region and our communities, we will use our resources wisely and strategically to:

Improving the health and wellbeing of communities requires a more broad approach than the traditional boundaries of health and social services. Partnership with communities (including Councils, Government Agencies, NGOs from other sectors and community organisations) is required to better respond to the social determinants of health.

In setting the strategic priorities necessary to achieving this vision, CCDHB is guided by core legislative and governmental strategic directions, including:

- the Treaty of Waitangi
- the New Zealand Health Strategy
- He Korowai Oranga – the Māori Health Strategy
- Ala Mo'ui: Pathways to Pacific Health and Wellbeing 2014-2018.

- the Healthy Ageing Strategy

CCDHB is also guided by the Government's commitment to the United Nations Convention on the Rights of Persons with Disabilities.

CCDHB is well placed to successfully deliver against the New Zealand Health Strategy objectives, as we implement our longer term view of how services will be delivered for our population. We will operate with a long-term view supported by the ten-year Long-Term Investment Plan. To do this we have a programme of work that builds on existing successes and finds new ways.

CCDHB is committed to focus in key areas:

- Equity: CCDHB is investing to sustainably implement equity, with a focus on those where inequitable outcomes have the greatest negative impact for Māori and also for Pacific people, those in lower socio economic status, those with enduring mental illness and those with disability. Specific equity initiatives are outlined in the planning priority section.
- Improving Performance: CCDHB continues on a pathway to improve system performance and outcomes for our communities. We are taking a "simplify/intensify" approach to service provision; services for those with resources are simpler, while services for those with less resources are intensified.
- Regional Collaboration: CCDHB has close sub-regional relationships with Hutt Valley and Wairarapa DHBs. For 2018/19, CCDHB will strengthen the shared planning processes across Hutt Valley and CCDHB as we move to a shared Chief Executive.
- Primary Care: The Healthcare Home is a key priority for CCDHB, as we move to develop our Community Health Networks. The emphasis in year three of this programme is on equity and ensuring models of service delivery are effective for our Māori and Pacific communities as well as those with disability and enduring mental illness. This includes access to after-hours primary care especially on the Kāpiti Coast.
- Hospital Specialist Services: CCDHB is committed to improving regional care arrangements with our partner DHBs as the tertiary specialist provider in the Central Region.
- Mental Health and Addictions: CCDHB is facing a growing need for mental health and additional services. CCDHB has a comprehensive programme of work to prepare for implementation of the Mental Health Inquiry recommendations.
- Financial Sustainability: CCDHB remains on a target pathway to achieve breakeven. In this Annual Plan we will achieve the agreed target for 2018/19. Actions within this Annual Plan contribute to manage demand and support a health system that is more sustainable in 2019/20.
- Capital Issues: The build of a new Children's Hospital is underway with the support of Treasury and MoH. Capital investment is under review as part of the Long Term Investment Planning process and we will ensure MoH are appraised of any significant requirements as they arise.

For the 2019/20 year, CCDHB will especially support the Ministers priorities:

- A strong and equitable public health and disability system
- Mental Health and Addictions care,
- Child Wellbeing,
- Primary health care, and
- Environmental sustainability and drinking water safety

Message from the Chair

(Placeholder for 'Message from the Chair')

Message from the Chief Executive

(Placeholder for 'Message from the Chief Executive')

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Signature Page

Agreement for the Capital and Coast DHB 2019/20 Annual Plan between

Hon. Dr. David Clark
Minister of Health
Date:

Hon. Grant Robertson
Minister of Finance
Date:

Andrew Blair
Chair
Date:

Dame Fran Wilde
Deputy Chair
Date:

TBA
Chief Executive
Date:

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SECTION TWO: Delivering on Priorities

This section outlines CCDHB's commitment to deliver on the Minister's Letter of Expectations and key activities and milestone to deliver on the Planning Priorities. More information on the Ministry's performance measures is provided in Section 5 Performance Measures.

2.1 Health Equity in DHB Annual Plans

Improving equity performance is a priority for CCDHB. Equity is about looking at how well different population groups are doing compared with each other, identifying where the differences are and working to close the gap. We know that we don't do as well for Māori and Pacific Peoples in our district as we aim to, and we can see this in the health statistics. CCDHB is also committed to improving health outcomes and achieving equity for people who have low socio-economic status, and those with an enduring mental illness and/or addiction, or those who have a disability.

Our strategic priorities for addressing equity in 2019/20 include: the delivery of the Taurite Ora Action Plan and the CCDHB Equity Strategy 2019-2030, as well as further delivery of Toe Timata Le Upega, the Pacific Action Plan 2017-2020 and the Sub-Regional Disability Strategy 2017-2022. The development of the CCDHB Pro-Equity Strategy puts in place the building blocks for CCDHB to advance as a pro-equity organisation.

In this Annual Plan we continue to address some of the drivers of inequities to improve outcomes particularly for Māori and Pacific Peoples and other populations experiencing inequities. CCDHB will deliver on equity priorities through the specific actions and milestones outlined in the section below.

2.2 Māori health

CCDHB is developing a new Māori health strategy, Taurite Ora: CCDHB's Māori Health Strategy and Action Plan 2019-2030, which will guide DHB activity to achieve equitable Māori health outcomes in the CCDHB district by 2025 with a broader goal of 'pae ora', (health futures for Māori) by 2030. The plan is to be released in 2019.

Taurite Ora describes how complex health is and the critical need to improve health outcomes for Māori, yet its success will be dependent upon CCDHB keeping the solutions simple, where Māori, whanau, communities and DHB staff and providers can see themselves as part of those solutions.

The strategy focuses on **equity**, as a value which underpins everything we do, and system change through **workforce** development and funding prioritisation through **commissioning** of services.

Taurite Ora has two goals:

i) to create a stronger and more responsive Capital and Coast Health System and

ii) improved health and wellbeing outcomes for Māori.

Goal one will be achieved by focusing on three strategic priorities: becoming a pro-equity health organization, growing and empowering out workforce and equitable and effective commissioning. Goal two focusses on two priority focus areas - maternal child and youth, and mental health and addictions.

CCDHB's Māori Partnership Board continues to guide the development of the strategy. Additionally, DHB staff, Māori & community providers and respected Māori academics have been key advisors in the development of the strategy.

2.3 Government Planning Priorities

2.3.1 Strong and equitable public health and disability system

New Zealanders are living longer, but also spending more time in poor health.

This means we can expect strong demand for health services in the community, our hospitals, and other care settings.

Responding to this challenge will require effective and co-ordinated care in the community supported by strategic capital investment, workforce development, and joined-up service planning to maximise system resources and to improve health and increase equity.

Engagement and obligations as a Treaty partner

The NZPHD Act specifies the DHBs Treaty of Waitangi obligations; please specify in the annual plan the processes the DHB uses to meet these obligations. This includes, but is not limited to, information on:

- meeting the DHBs obligation to establish and maintain processes that enable Māori to participate in, and contribute to, strategies for Māori health improvement
- meeting processes that enable Māori to participate in, and contribute to, strategies for Māori health improvement
- fostering the development of Māori capacity for participating in the health and disability sector and for providing for the needs of Māori
- building the capability of all DHB staff in Māori cultural competency and Te Tiriti o Waitangi.

This is an equitable outcomes action (EOA) focus area

DHB activity	**Milestone**	**Measure**	Government theme: Improving the well-being of New Zealanders and their families	
This activity is led by CCDHB Maori Health Strategy – Taurite Ora 1. Complete, publish and launch **Taurite Ora**: CCDHB's Māori Health Strategy and Action Plan 2019-2030 (EOA) 2. Continue to support the **Māori Partnership Board** function as an overseer, contributor, and monitor of Māori health within CCDHB (EOA) 3. Develop a **pathway for increasing the number of Māori** workforce across all areas of the organisation (EOA) 4. Provide **cultural competency training** opportunities for all staff including Tikanga training, Te Tohu Whakawaiora and Te Reo classes (EOA)	Q1: Taurite Ora published 2. Bi-monthly MPB meetings 3. Q4: pathway developed 4. Q4: report against outcome	SS12	System outcome We have improved quality of life (health maintenance and independence)	Government priority outcome Support healthier, safer and more connected communities
			System outcome We have improved health equity (healthy populations)	Government priority outcome Make New Zealand the best place in the world to be a child
			System outcome We live longer in good health (prevention and early intervention)	Government priority outcome Ensure everyone who is able to, is earning, learning, caring or volunteering

Cross-sectoral collaboration

- Please outline in your plan how the DHB has, and will continue to, demonstrate leadership in the collaboration between and integration of health and social services, especially housing.

This is an equitable outcomes action (EOA) focus area

<table>
<tr><td rowspan="4">DHB activity
This activity is an important part of locality planning focusing on the needs of our communities by working in collective partnership models.
1. Cross-sectoral collaboration with Wellington City Council, Housing New Zealand and Ministry of Housing and Development to develop a coordinated plan in line with the Housing First principles to respond to homelessness in Wellington City (EOA)
2. Partnering with health social care providers to implement an integrated youth service in Porirua (EOA)</td><td rowspan="4">Milestone
1. Q1 – Q4
2. Q1 – Q4
3. Q1 – Q4</td><td rowspan="4">Measure
SS (TBC)</td><td colspan="2">Government theme:
Improving the well-being of New Zealanders and their families</td></tr>
<tr><td>System outcome
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<table>
<tr><td colspan="5">Strategic health measures
TBC following government decision

This is an equitable outcomes action (EOA) focus area
(equity focus and clear actions to improve Māori and Pacific Peoples health outcomes)</td></tr>
<tr><td rowspan="4">DHB activity

(Placeholder – awaiting further guidance from MoH)</td><td rowspan="4">Milestone

TBC</td><td rowspan="4">Measure

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(prevention and early intervention)</td><td>Government priority outcome
Ensure everyone who is able to, is earning, learning, caring or volunteering</td></tr>
</table>

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Disability

- Commit to ongoing training for front line staff and clinicians that provides advice and information on what needs to be considered when interacting with a person with a disability. Report on what percentage of staff have completed the training by the end of quarter 4 2019/20.
- Outline in your plan how the DHB collects and manages patient information to ensure your staff know which patients have visual, hearing, physical and/or intellectual disabilities

This is an equitable outcomes action (EOA) focus area

(equity focus and clear actions to improve Māori and Pacific Peoples health outcomes)

DHB activity	**Milestone**	**Measure**	Government theme: Improving the well-being of New Zealanders and their families	
This activity is led by the 3DHB Disability Strategy. Sub-Regional Disability Strategy 2017 – 2022 Wairarapa, Hutt Valley and Capital & Coast District Health Boards **Enabling Partnerships: Collaboration for effective access to health services** 1. Continue work through our SubRegional Māori and Pacific Ropu for Māori and Pacific People with disabilities to determine goals and priorities to improve access to services (EOA) 2. Implement a disability education plan that incorporates a rights based approach to reduce inequitable health outcomes across the disabled, Māori and Pacific communities. (EOA) 3. Complete a disability survey with our workforce to better understand the areas where capability development is required. The next steps on this process are currently being worked through but will be endorsed by the Sub Regional-Disability Advisory Group which will include Māori and Pacific input. 4. Continue quality improvement processes on the Disability Responsiveness eLearning Module to all staff 5. Continue to improve patient experiences by including further information about a patient's sensory, physical, intellectual disabilities on our Disability Alerts including implementing a quality standard which is measured.	1. Q1-Q2: review barriers to equitable access; Q3-Q4: Develop a plan to support uptake by Māori and Pacific Peoples. 2. Q1: Review education material; Q2: develop plan. 3. Q1-2: develop survey; Q3: Release of survey; Q4: Analyse results from the survey. 4. Q4: Report on % staff completed training. 5. Q1: develop quality standard; Q3/4: Review	SS *(TBC)*	System outcome We have improved quality of life (health maintenance and independence)	Government priority outcome Support healthier, safer and more connected communities
			System outcome We have improved health equity (healthy populations)	Government priority outcome Make New Zealand the best place in the world to be a child
			System outcome We live longer in good health (prevention and early intervention)	Government priority outcome Ensure everyone who is able to, is earning, learning, caring or volunteering

	attainment against standard every 6 months			

Planned Care Advice on local Planned Care actions are being reviewed as part of the Planned Care refreshed Strategic approach work currently underway. *Further information to be advised in early 2019.*			This is an equitable outcomes action (EOA) focus area (equity focus and clear actions to improve Māori and Pacific Peoples health outcomes)	
DHB activity *(Placeholder – awaiting further guidance from MoH)*	Milestone *TBC*	Measure SS *(TBC)*	Government theme: Improving the well-being of New Zealanders and their families	
			System outcome We have improved quality of life (health maintenance and independence)	Government priority outcome Support healthier, safer and more connected communities
			System outcome We have improved health equity (healthy populations)	Government priority outcome Make New Zealand the best place in the world to be a child
			System outcome We live longer in good health (prevention and early intervention)	Government priority outcome Ensure everyone who is able to, is earning, learning, caring or volunteering

Acute Demand

Acute Data Capturing:

- Please provide a plan on how the DHB will implement SNOMED coding in Emergency Departments to submit to NNPAC by 2021. For example, this should include a description of the information technology actions and ED clinical staff training actions, milestones and timeframes.

Patient Flow:

- Please provide an action that improves patient flow for admitted patients
- Please provide an action that improves management of patients to ED with long-term conditions

This is an equitable outcomes action (EOA) focus area

(equity focus and clear actions to improve Māori and Pacific Peoples health outcomes)

- Please provide an action focused on improving wait times for patients requiring mental health and addiction services who have presented to the ED
- Please provide an action to improve Māori patients experience in ED

DHB activity	**Milestone**	**Measure**	Government theme: Improving the well-being of New Zealanders and their families	
CCDHB has a focus on acute demand that both manages, flow into the hospital and effectively manages flow within our hospitals. 1. **SNOMED coding in Emergency Departments:** Work with the Ministry on developing a plan on how CCDHB can implement SNOMED coding in its Emergency Department: • scoping and assessing feasibility within current systems and constraints (and within clinical workflows), • liaising and consulting with sub-regional DHBs on a coordinated approach • developing and assessing implementation options including a business case. 2. **Improve patient flow for admitted patients**: Roll out daily discharge planning board rounds for all acute services. 3. Improve **management of patients to ED with Long-Term Conditions**: • Collaborate with the Healthcare Home to avoid or reduce presentations of patients with chronic conditions to ED. • Strengthen multidisciplinary meetings regarding frequent attenders to ED including their primary care provider. • Continue to assess and manage frail elderly patients presenting to ED, often avoiding admission by ongoing community support. See action 3 in Healthy Ageing.	1. Q4 2. Q1: Roll out of daily discharge planning board rounds for all acute services 3. Q1-Q4 4. Q1: analysis of current data with an equity focus; Q1: embed Tikanga practices; Q2: Develop new policies in alignment with Tikanga Māori; Q3: Decrease the number of Māori who leave after being triaged	SS *(TBC)* SS10	System outcome We have improved quality of life (health maintenance and independence)	Government priority outcome Support healthier, safer and more connected communities
			System outcome We have improved health equity (healthy populations)	Government priority outcome Make New Zealand the best place in the world to be a child
			System outcome We live longer in good health (prevention and early intervention)	Government priority outcome Ensure everyone who is able to, is earning, learning, caring or volunteering

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4. 'Equity for Māori in Wellington Emergency Department' Project: a Māori-led project designed to support a goal of being a pro-equity service that will meet the needs of Māori patients, whānau and staff. 5. **Improve wait times for patients requiring mental health and addiction services** who have presented to the ED:	and before being seen by a doctor. 5. *TBC*			

Healthy Ageing

Implement actions identified in the Healthy Ageing Strategy 2016 and contribute to the Government's priority of 'Improving the wellbeing of New Zealanders and their families', as follows:

- working with ACC, HQSC and the Ministry of Health to promote and increase enrolment in Strength and Balance programs and improvement of osteoporosis management especially in alliance with Primary Care as reflected in the associated "Live Stronger for Longer" Outcome Framework (This expectation aligns most closely to the Government's 'Prevention and Early Detection' priority outcome; and the Ageing Well and Acute and Restorative Care goals of the Healthy Ageing Strategy)
- aligning local DHB service specifications for home and community support services (HCSS) to the vision, principles, core components, measures and outcomes of the national framework for HCSS (This expectation aligns most closely to the Government's 'Health Maintenance and Independence' priority outcome; and the Living Well with Long-Term Conditions goal of the Healthy Ageing Strategy)

- In addition, please outline current activity to identify and address the drivers of acute demand for people 75 plus presenting at ED (or at lower ages for disadvantaged populations) (This expectation aligns most closely to the Government's 'Prevention and Early Detection' priority outcome; and the Acute and Restorative Care goal of the Healthy Ageing Strategy.)

This is an equitable outcomes action (EOA) focus area

(equity focus and clear actions to improve Māori and Pacific Peoples health outcomes)

DHB activity	**Milestone**	**Measure**	Government theme: Improving the well-being of New Zealanders and their families	
1. Continue to work with ACC, HQSC and the Ministry of Health to promote and increase enrolment in **Strength and Balance programs** and improvement of osteoporosis management; Implementation and monitoring of the 3DHB Community Falls Management Programme. 2. Ensure that local Service Specifications align to the vision, principles, core components, measures and outcomes of the national framework for	1. Q1-Q4: Quarterly Reporting 2. Q1: Service Specs aligned	SS *(TBC)* SS04	System outcome We have improved quality of life (health maintenance and independence)	System outcome We have improved quality of life (health maintenance and independence)

home and community support services (HCSS): CCDHBs service specifications and model of funding aligns with the National framework. CCDHB is in the process to transition to two providers of HCSS in 2019. 3. **Address the drivers of acute demand for people 75 plus presenting at ED**: Implement the extended community based HOP team focussed on early intervention and management of the frail and pre-frail older person group. 4. Pacific Neighbourhood Nurse Led Service in Porirua to support Pacific individuals, families, and communities to manage their health needs in the context of complex life situations and circumstances. (EOA) 5. Define and implement an integrated palliative care model of care. 6. Advance Care Planning is trialled with Māori, Pacific Peoples and dementia groups to understand cultural influences, barriers and information implementing ACP with these groups. (EOA)	3. Q2: Service defined, Q4: Staff recruited. 4. Q1-4: Quarterly Reporting 5. Q2: Palliative care model of care designed, Q3: Key stakeholder consultation. 6. Trials with Māori, Pacific Peoples and Dementia groups completed.		System outcome We have improved health equity (healthy populations) System outcome We live longer in good health (prevention and early intervention)	System outcome We have improved health equity (healthy populations) System outcome We live longer in good health (prevention and early intervention)

Improving Quality

Identify actions to improve equity in outcomes and patient experience by demonstrating planned actions to:

- work to improve equity in outcomes as measured by the Atlas of Healthcare Variation (DHB to choose one domain from: gout, asthma, or diabetes)
- improve patient experience as measured by your DHB's lowest-scoring responses in the Health Quality & Safety Commission's national patient experience surveys

System Level Measures

Implementation of the System Level Measures (SLMs) continues in 2019/20. The *Guide to Using the System Level Measures Framework for Quality Improvement* (SLM guide), which has been updated and should be used for the

This is an equitable outcomes action (EOA) focus area

(equity focus and clear actions to improve Māori and Pacific Peoples health outcomes)

development of the Improvement Plans and should be used in conjunction with *The System Level Measures – Annual Plan guidance 19/20*.

Antimicrobial resistance

High quality health care needs to address the challenge posed by antimicrobial resistance to current and future care pathways. Hospitals, primary care and residential care settings all need to ensure that front-line infection prevention and control practices are implemented continuously, effectively and consistently.

DHBs need to continue to align their activities with the *New Zealand Antimicrobial Resistance Action Plan* (MoH 2017).

DHB activity	**Milestone**	**Measure**	Government theme: Improving the well-being of New Zealanders and their families	
1. **Atlas of Healthcare Variation – Gout**: Development and implementation of a project with community pharmacies (within the Porirua basin) to measure urate levels and adjust medication dosage where appropriate to prevent Gout. Pharmacies will also support adherence to the medications once the optimal dose is reached. 2. **Improve Patient Experience**: please see the SLM Improvement Plan 3. **System Level Measures**: please see SLM Improvement Plan in Appendix B 4. **Antimicrobial resistance**: CCDHB will continue to comply with the New Zealand Antimicrobial Resistance Actions Plan. Activities for 2019/20 include: continuous surveillance of both multidrug resistant organisms (MDRO) and hospital-associated cases of CDI, update the policies for 'active screening for MDRO' and 'transmission based precautions', hand hygiene auditing across all inpatient areas, antimicrobial stewardship rounds, and anti-infective use point prevalence surveys. 5. **Antimicrobial resistance**: CCDHB will continue to support residential care providers to meet the Infection Control Standard (HDS(IPC)S.2008:3.1) through a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This will be through the implementation of an appropriate infection prevention and control (IPC) programme.	1. Q1: project initiated; Q2 initial assessment 2. SLM reporting 3. SLM reporting 4. Q1: Policies for 'active screening for MDRO' and 'transmission based precautions' updated; Q1: AMS rounds commenced; Q2: HH auditing to include all inpatient areas; Q2 and Q4: Anti-infective use point prevalence surveys completed	SS *(TBC)*	System outcome We have improved quality of life (health maintenance and independence)	Government priority outcome Support healthier, safer and more connected communities
			System outcome We have improved health equity (healthy populations)	Government priority outcome Make New Zealand the best place in the world to be a child
			System outcome We live longer in good health (prevention and early intervention)	Government priority outcome Ensure everyone who is able to, is earning, learning, caring or volunteering

	5. Q4: Audited facilities to comply with standards			

Cancer Services

Further guidance on the Standards of Care for cancer will be included in the February 2019 update.

This is an equitable outcomes action (EOA) focus area (equity focus and clear actions to improve Māori and Pacific Peoples health outcomes)

Cancer is the leading cause of morbidity in New Zealand, accounting for nearly one third of all deaths with 22,000 new cases diagnosed each year. Inequalities between Māori and non-Māori persist. Māori have a higher incidence of many cancers, are diagnosed with more advanced cancers, experience issues that impact on treatment options and are 1.7 times more likely to die from cancer than non-Māori New Zealanders.

Key strategies and plans to help inform DHB Annual Plans are listed below:

New Zealand Cancer Plan

Cancer Health Information Strategy

National Radiation Oncology Plan

DHBs will describe and implement improvements in accordance with national strategies and be able to demonstrate initiatives that support key priority areas as outlined below. All initiatives will demonstrate clear strategies for addressing Māori health gain, equitable and timely access to services and the use of data to inform quality improvement across those initiatives.

DHBs will describe actions to:

- ensure equity of access to timely diagnosis and treatment for all patients on the Faster Cancer Treatment (FCT) pathway (e.g. system/service improvements to minimise breaches of the 62 day FCT target for patient or clinical consideration reasons)
- develop a quality improvement plan for bowel cancer care informed by the Bowel Cancer Quality Improvement Report 2018 and associated data
- provide people who have completed cancer treatment with services to improve quality of life and to live well beyond cancer. Examples of the services are:

<table>
<tr><td colspan="5">

end of treatment meeting or clinic
the development of follow-up care plans for both secondary and primary health care.
referrals to appropriate service providers for self-care such as nutrition, physical therapy and psychosocial support.

</td></tr>
<tr><td>DHB activity
CCDHB has a whole of service cancer improvement programme.
1. Support regional coordination to improve cancer systems and services to ensure health gain for Māori and equitable and timely access to cancer services. (EOA)
2. Implement recommendations from cancer model of care reviews and establish work programme to support increased access to care, while reducing health disparities, integrating health care across our health system.
3. Progress further implementation of the MOSAIQ oncology management system at CCDHB, to provide improved patient safety with the utilisation of standardised prescribing protocols, quality checklists, etc. enhancing scheduling opportunities for outreach treatment delivery</td><td>Milestone
1. Q4: Work with Māori and Pacific health units to have cancer respective Māori and Pacific Cancer nurse coordinator or navigator type roles
2. Q4: Enhance a tumour stream model of care to improve access and participation in treatment.
3. Q4: Increasing the outreach treatment delivery for patients to have services provided closer to home.</td><td>Measure
SS (TBC)
SS01</td><td colspan="2">Government theme:
Improving the well-being of New Zealanders and their families</td></tr>
<tr><td></td><td></td><td></td><td>System outcome
We have improved quality of life
(health maintenance and independence)</td><td>Government priority outcome
Support healthier, safer and more connected communities</td></tr>
<tr><td></td><td></td><td></td><td>System outcome
We have improved health equity
(healthy populations)</td><td>Government priority outcome
Make New Zealand the best place in the world to be a child</td></tr>
<tr><td></td><td></td><td></td><td>System outcome
We live longer in good health
(prevention and early intervention)</td><td>Government priority outcome
Ensure everyone who is able to, is earning, learning, caring or volunteering</td></tr>
</table>

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<table>
<tr><td colspan="3">Bowel Screening
Guidance will be included in the February 2019 update.</td><td colspan="3">This is an equitable outcomes action (EOA) focus area
(equity focus and clear actions to improve Māori and Pacific Peoples health outcomes)</td></tr>
<tr><td>DHB activity

(Placeholder – awaiting further guidance from MoH)</td><td>Milestone

TBC</td><td>Measure

SS (TBC)</td><td colspan="2">Government theme:
Improving the well-being of New Zealanders and their families</td></tr>
<tr><td rowspan="3"></td><td rowspan="3"></td><td rowspan="3"></td><td>System outcome
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Ensure everyone who is able to, is earning, learning, caring or volunteering</td></tr>
</table>

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Healthy food and drink

Create supportive environments for healthy eating and health weight by undertaking the following activities:

- Commit to implementing Healthy Food and Drink Policies in DHBs that align with the National Healthy Food and Drink Policy.
- Commit to including a clause in your contracts with health provider organisations stipulating an expectation that they develop a Healthy Food and Drink Policy covering all food and drinks sold on site/s, and provided by their organisation to clients/service users/patients[1], staff and visitors under their jurisdiction. Any policy must align with the Healthy Food and Drink Policy for Organisations (https://www.health.govt.nz/publication/healthy-food-and-drink-policy-organisations).
- Commit to reporting in Q2 and Q4 on the number of contracts with a Healthy Food and Drink Policy, and as a proportion of total contracts.

This is an equitable outcomes action (EOA) focus area

(equity focus and clear actions to improve Māori and Pacific Peoples health outcomes)

DHB activity	**Milestone**	**Measure**	Government theme: Improving the well-being of New Zealanders and their families	
1. Align the 3DHB food and beverage guidelines with the national Policy (with the exception of drinks which will remain stricter than the national Policy). Finalise the implementation of the food and beverage guidelines (one phase outstanding: gifts and fundraising). 2. Continue to monitor all foodservice providers on site to establish compliance levels. 3. CCDHB and 3DHB food and beverage guidelines and policies included in: • Tender documents for all outsourced café and coffee services • General services tender (includes patient meals and staff cafeteria) Compliance with the guidelines and policy are included in the evaluation criteria and dietetic personnel utilised in the evaluation process. 4. A Healthy Food and Drink Policy clause will be included in contracts with community providers	1. Q4: Guideline implemented 2. Q2: Food service providers audited; Q4: plan developed to correct any non-compliant areas. 3. Q4: Food and beverage clauses included in all Tender documents 4. Q2 and Q4: Report on number of community contracts	SS *(TBC)*	System outcome We have improved quality of life (health maintenance and independence)	Government priority outcome Support healthier, safer and more connected communities
			System outcome We have improved health equity (healthy populations)	Government priority outcome Make New Zealand the best place in the world to be a child
			System outcome	Government priority outcome

1 Excluding inpatient meals and meals on wheels

	with a Healthy Food and Drink Policy		We live longer in good health (prevention and early intervention)	Ensure everyone who is able to, is earning, learning, caring or volunteering

Workforce

In responding to this priority area please cross-reference to Section four: Stewardship - Workforce section

DHB workforce priorities

Set out any workforce actions, specific to your DHB that you intend to work on in the 2019/20 planning year. Outline how these actions relate to both a strong public health system and EOA focus area actions. Ensure that you have considered workforce actions for the priority areas in your plan, especially mental health and child health.

Any workforce actions should be mindful of:

- Ongoing responsibilities for the upskilling, education and training of health work forces
- The population health need that initiatives are designed to address
- The desired health outcomes the initiatives will help to address, including equitable outcomes for populations
- An assessment of how the initiatives align with the priority areas of strong fiscal management, strong public health system, and primary care
- Evidence that consideration has been given to making best use of the service delivery mechanisms that make best use of interdisciplinary teams to support health workforces in their roles across primary, secondary and tertiary settings.

Workforce Diversity

This action area builds upon actions set out in the 2018/19 Regional Services Plans to better understand the workforce intelligence gathered at local, regional and national levels and how this intelligence assists DHBs in workforce planning.

DHBs will work in collaboration with DHB Shared Services and, where appropriate, with the Ministry of Health to:

This is an equitable outcomes action (EOA) focus area

(equity focus and clear actions to improve Māori and Pacific Peoples health outcomes)

Examples of equity actions that could be included in your plan:

- increase Māori participation and retention in health workforces and ensure that Māori have equitable access to training opportunities as others
- build cultural competence across the whole health workforce
- increase participation of Pacific people in health workforces
- form alliances with educational institutes (including secondary and tertiary) and local iwi to identify and implement best practices to achieve Māori health workforces that matches the proportion of Māori in the population.

- identify workforce data and intelligence that is collected across services and DHB areas, understanding workforce trends to inform workforce planning
- understand the workforce data and intelligence requirements that best supports DHBs in order to undertake evidence-based workforce planning
- support your responsibility to upskilll, provide education and train health work forces
- provide training placements and support transition to practice for eligible health work force graduates and employees. Planning must include PGY1, PGY2 and CBA placements, and how requirements for nursing, allied health, scientific and technical health work forces in training and employment will be met
- form alliances with training bodies such as educational institutes (including secondary and tertiary), professional colleges, responsible authorities, and other professional societies to ensure that we have a well trained workforce.

Health Literacy

The purpose of the actions set out in this advice is to build upon the health literacy review that your DHB completed in the 2018/19 planning year towards developing a health literate organisation.

As a result of the health literacy review, and if you do not have one already in place, develop a Health Literacy Action Plan that describes the service improvements you plan to make in the short, medium and long term.

Outline any actions within the Health Literacy Action Plan that support a health system focus on:

- services being easy to access and navigate
- effective health worker communication
- clear and relevant health messages that empower everyone to make informed choices.

Where health literacy actions are set out in other sections of the annual plan ensure that these are considered within the Health Literacy Action Plan, as well as briefly cross-referencing these actions in this section.

DHB activity	**Milestone**	**Measure**	Government theme: Improving the well-being of New Zealanders and their families	
1. **DHB workforce priorities**, workforce actions for 2019/20 include: • Child Health: Develop a Midwifery Workforce Strategy (*see section 2.3.3: midwifery workforce – hospital and LMC*) • Mental Health:	1. Q3: Midwifery Workforce Strategy Developed; 4. *TBC*	SS *(TBC)*	System outcome We have improved quality of life	Government priority outcome

• Māori and Pacific Workforce: 2. **Workforce Diversity,** CCDHB will continue to work with DHB Shared Services to: • identify workforce data and intelligence • understand the workforce data and intelligence requirements • support to upskilll, provide education and train health work forces • provide training placements and support transition to practice for eligible health work force graduates and employees (including PGY1, PGY2 and CBA placements) • form alliances with training bodies (educational institutes, professional colleges, responsible authorities, and other professional societies) 3. **Health Literacy**, workforce actions for 2019/20 include: • CCDHB has a Health System Plan 2030. This Plan outlines our commitment to ensuring all services are coherent and meet the needs of our community. • Develop and commence implement of the health literacy plan alongside the Health System Plan 2030. 4. **Allied Health Model of Care** work – strengthening AHST leadership 5. Development of an **Inter-professional Workforce** P**lan**, which includes addressing vulnerable workforces and future workforce needs 6. Build **cultural competence** across the whole health workforce • Provide cultural competency training opportunities for all staff including Tikanga training, Te Tohu Whakawaiora and Te Reo classes (EOA) (*see section 2.3.1: Engagement and obligations as a Treaty partner*)	5. *TBC* 6. Q4: report against outcome		(health maintenance and independence)	Support healthier, safer and more connected communities
			System outcome We have improved health equity (healthy populations)	Government priority outcome Make New Zealand the best place in the world to be a child
			System outcome We live longer in good health (prevention and early intervention)	Government priority outcome Ensure everyone who is able to, is earning, learning, caring or volunteering

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Data and Digital

In responding to this priority area please cross-reference to Section four: Stewardship - IT section

All DHBs:

- Demonstrate how you are improving equity in your current and future digital systems/investments
- Indicate plans for complying with approved standards and architecture in all future systems/investment
- Indicate plans for the provision of health services (such as public health, mental health, child wellbeing, primary care) via digital technology across the health system; for example telehealth, integrated care and working remotely.
- Explain how your IT Plan is aligned with the Regional ISSP including your risk mitigation.
- Demonstrate where you are aligning with national/regional initiatives and those leveraging investments.
- Demonstrate how you plan to implement Application Portfolio Management including the lifecycle for IT systems i.e. planned upgrades, support, licence renewal, etc.
- Demonstrate how you will incorporate IT security maturity improvement across all your digital systems.

This is an equitable outcomes action (EOA) focus area

(equity focus and clear actions to improve Māori and Pacific Peoples health outcomes)

DHB activity	Milestone	Measure	Government theme: Improving the well-being of New Zealanders and their families
1. Improving equity through digital systems/investments (EOA): a. Multilingual versions of an electronic Patient Experience Survey b. Sharing a patient's Pacific Health service record to other clinicians involved in their care c. Electronic Referrals from hospital services (including Emergency Department) to community providers. a. Making the Māori keyboard (including ability to add macrons) the standard profile b. Extending free patient Wi-Fi to the outpatients c. Improving access to data and analytical report for Māori & Pacific services d. Implement electronic Health Passport for Disabilities	(a) Q3: Business case implemented (b) Q2: Implemented (c) Q4: Pilot for referrals to Asthma educators implemented (d) Q1: Implemented (e) Q2: Implemented (f) Q4: Implemented (g) Q3: Implemented	SS *(TBC)*	

2. Leveraging approved standards and architecture a. Health Information Security Framework: Completion of a Security Improvement work plan for 2019-21 based on the findings of the independent review against HISF b. Allied Health Data Standard: Completion of the Allied Health Activity Capture project which will improve the Allied Health service's ability to meet the data standard c. SNOMED CT: Feasibility analysis of implementing SNOMED CT in Emergency Department d. Clinical Document Architecture: Implementation of a FHIR (Fast Health Interoperability Resources Standard) capability & server	(a) Q1: Plan Completed (b) Q1: Implemented: (c) Q1: Analysis completed (d) Q1: Implemented		System outcome We have improved quality of life (health maintenance and independence)	Government priority outcome Support healthier, safer and more connected communities
3. Supporting new models of health care delivery through technology a. Shared Care Planning – Implementation of a Shared Care Plan system b. Extending use of Zoom to other services to support new models of care including telehealth and Multi-Disciplinary Meetings	(a) Q1: Implemented; (b) Q4: Progressed		System outcome We have improved health equity (healthy populations)	Government priority outcome Make New Zealand the best place in the world to be a child
4. Leveraging Regional and National Initiatives a. Regional RIS – Complete transition to the Regional Radiology Information System b. Regional Clinical Portal – Complete the replication of data from local Clinical Data Repositories into the Regional Clinical Data Repository c. National Bowel Screening – Transition onto the National Bowel Screening Platform	(a) Q2: Implemented; (b) Q2: Completed; (c) Q2: Transitioned		System outcome We live longer in good health (prevention and early intervention)	Government priority outcome Ensure everyone who is able to, is earning, learning, caring or volunteering
5. Implementing Application Portfolio Management a. Long Term Investment Plan – Completion of the ICT Asset Management Plan	Q2: Completed			

6. Mobile ePatient Observations (MEPO): Complete Implementation of Business Case	Q1: Implementation Business Case Completed			
7. eMedication Management a. Link NZePS Data to discharge documentation and improve discharge information to include medication on admission, on discharge and changes with reasons b. Implement a new ePrescribing solution for Addiction Services with connection to NZePS c. Complete search and selection of a Hospital prescribing and administering system d. Complete Implementation Business Case	(a) Q4: Implementation (b) Q4: Implementation (c) Q2: RFP Completed (d) Q4: Implementation Business Case Completed			
8. Cath Lab System: complete implementation of a replacement Cath Lab system	Q2:Implementation Completed			
9. Medical Oncology System: Complete implementation of a replacement Medical Oncology system	Q2:Implementation Completed			

Delivery of Regional Service Plan (RSP) priorities • Identify any significant actions the DHB is undertaking to deliver on the Regional Service Plan. Note: RSP guidance will be released in early 2019.			This is an equitable outcomes action (EOA) focus area (equity focus and clear actions to improve Māori and Pacific Peoples health outcomes)
DHB activity	**Milestone**	**Measure**	Government theme: Improving the well-being of New Zealanders and their families

(Placeholder – awaiting further guidance from MoH)	*TBC*	SS02	System outcome We have improved quality of life (health maintenance and independence)	Government priority outcome Support healthier, safer and more connected communities
			System outcome We have improved health equity (healthy populations)	Government priority outcome Make New Zealand the best place in the world to be a child
			System outcome We live longer in good health (prevention and early intervention)	Government priority outcome Ensure everyone who is able to, is earning, learning, caring or volunteering

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2.3.2 Mental Health and Addictions care

Mental health and addictions is a priority work programme for Government, the Ministry of Health and District Health Boards.

DHBs will contribute to the independent/ high quality of life for New Zealanders with mental health and addiction concerns by ensuring their mental health services are cost effective, results focused and have regard to the service impacts on people who are severely affected by mental illness. The DHB will provide people with better health and disability services by ensuring that the range of services closes existing service gaps, and makes them easier to access. The range of services will be of high quality, safe, evidence based and provided in the least restrictive environment.

The Governments response and expectations from the Mental Health and Additions Inquiry will be articulated in updated Guidance to DHBs in March 2019.

<table>
<tr><td colspan="3">Inquiry into mental health and addiction
Please outline how your DHB will work to implement Government agreed actions following the Mental Health and Addiction Inquiry Report and implement relevant Budget 2019 appropriations (Further guidance will be provided following Government decisions).</td><td colspan="3">This is an equitable outcomes action (EOA) focus area
(equity focus and clear actions to improve Māori and Pacific Peoples health outcomes)</td></tr>
<tr><td rowspan="4">DHB activity

(Placeholder – awaiting further guidance from MoH)</td><td rowspan="4">Milestone

TBC</td><td rowspan="4">Measure

MH (TBC)
MH01
MH03
MH04</td><td colspan="2">Government theme:
Improving the well-being of New Zealanders and their families</td></tr>
<tr><td>System outcome
We have improved quality of life
(health maintenance and independence)</td><td>Government priority outcome
Support healthier, safer and more connected communities</td></tr>
<tr><td>System outcome
We have improved health equity
(healthy populations)</td><td>Government priority outcome
Make New Zealand the best place in the world to be a child</td></tr>
<tr><td>System outcome
We live longer in good health
(prevention and early intervention)</td><td>Government priority outcome
Ensure everyone who is able to, is earning, learning, caring or volunteering</td></tr>
</table>

Population mental health

- Outline actions to support healthier safer and more connected communities through better access to affordable, quality health care and better health outcomes for everyone. How will you improve population mental health and addiction by increasing uptake of treatment and support earlier in the course of mental illness and addiction, further integrating mental health, addiction and physical health care, and co-ordinating mental health care with wider social services, especially for priority populations including vulnerable children, youth, Māori and Pacifica.

DHBs should include actions in relation to improving some of the below areas of focus.

- Options for early intervention across the primary care spectrum to help ensure early intervention and continuity of care.
- Improved options for acute responses including improving crisis team responses and improved respite options.
- Supporting Parents Healthy Children (COPMIA) to support early intervention in the life course.
- Suicide prevention and postvention to provide a range of activities such as mental health literacy and suicide prevention training, community-led prevention and postvention initiatives (i.e., bereavement counselling) and integration of mental health and addiction services.
- Improving co-existing problems responses via improved integration and collaboration between other health and social services.
- Actions in relation to Equally Well to improve the physical health outcomes for people with low prevalence mental health and addiction conditions.
- Reducing inequities including reducing the rate of Māori under community treatment orders.
- Improving employment and education and training options for people with low prevalence conditions including, for example, Individual Placement Support.
- The implementation of models of care for addiction treatment, with particular reference to the commencement of the Substance Addiction (Compulsory Assessment and Treatment) Act 2017.

This is an equitable outcomes action (EOA) focus area

(equity focus and clear actions to improve Māori and Pacific Peoples health outcomes)

DHB activity	**Milestone**	**Measure**	Government theme: Improving the well-being of New Zealanders and their families

1. Development of **Community Mental Health Integration model** to implement the 3DHB Mental Health and Addictions Strategy-*Living Life Well 2019-2025.* (EOA) 2. **Suicide Prevention**-Increase capacity and improve responsiveness to suicide prevention and postvention across the 3DHB's. This will include the centralisation of prevention and postvention functions from external providers back into CCDHB to enable a more integrated, joined up approach across NGO's, Primary and secondary care providers. We will also have a focus on improving the responsiveness of the various touchpoints in the health sector (e.g. Emergency Departments) by implementing recommendations following a system review report commissioned in 18/19. (EOA) 3. **Increase primary care access** to clients with severe and enduring mental illness to address the mortality rate and risk of premature death for this population group (in line with Equally Well). Two key actions include the expansion of existing PHO contracts to provide free GP visits for opioid substitution clients (OST) and increased access to a primary mental health nurse (Ora Toa and Compass PHO's). (EOA) 4. Provision of support to complex AOD clients with severe/enduring addiction issues post SACAT. We will introduce a specialist addiction social worker role into a community provider to work with severe/enduring addiction clients post **SACAT**. (EOA) 5. Review NGO **wrap around support services** (housing, employment, home based support, navigation, family support) for moderate to severe clients based in the community to ensure services are responsive, culturally appropriate and relevant to current needs. (EOA)	1. Q1&2: Establish 3 locality based co-design groups to develop action plans to implement the strategy; Q3&4: Locality plans implemented. 2. Q1: Centralise functions and increase FTE capacity; Q2: Develop locality based working groups and action plans based on jointly agreed focus areas; Q3&4: Implement recommendations as per report 3. Q1: Extend contracts, services implemented; Q4: Review impact of services 4. Q1: Put new role in place with provider; Q4: Review impact of role 5. Q1: Complete review; Q2: Review recommendation with stakeholders and develop plan for changes; Q3&4: Implementation of proposed changes	MH *(TBC)*	System outcome We have improved quality of life (health maintenance and independence)	Government priority outcome Support healthier, safer and more connected communities
			System outcome We have improved health equity (healthy populations)	Government priority outcome Make New Zealand the best place in the world to be a child
			System outcome We live longer in good health (prevention and early intervention)	Government priority outcome Ensure everyone who is able to, is earning, learning, caring or volunteering

Mental health and addictions improvement activities

This is an equitable outcomes action (EOA) focus area

(equity focus and clear actions to improve Māori and Pacific Peoples health outcomes)

- In order to support an independent/high quality of life please outline your commitment to the HQSC mental health and addictions improvement activities with a continued focus on minimising restrictive care (including the aspirational goal of eliminating seclusion by 2020) and improving transitions and engagement with the next steps of the programme.

Please note the percentage and quality of transition plans forms part of the PP7 performance measure. The other three programmes that will be led by the HQSC over the life of the programme are; learning from serious adverse events and consumer experience, maximising physical health and improving medication management and prescribing issues. This programme will support standardised, evidence-based processes and practices for prescribing and management.

DHB activity	**Milestone**	**Measure**	Government theme: Improving the well-being of New Zealanders and their families	
1. **Seclusion**: Implement the programme of work is designed to ensure it incorporates effective strategies which will lead to improved experience of care and equitable outcomes for Māori and Pacific peoples. Focus of work this year is co-design of seclusion improvement activities with consumers, tāngata whaiora, family and whānau who use acute units, followed by testing of selected activities. 2. **Seclusion**: Continue model of improvement methodology to test improvement ideas gathered from co-design period. 3. **Te Whare Ahuru reconfiguration**: Redesign Te Whare Ahuru Acute Inpatient Unit to deliver best practice and culturally safe models of care (including for Māori and Pacific peoples) in a modern environment that is safe, restful and supports recovery and greater wellbeing 4. **Learning from Serious Adverse Events**: Development of programme of work for Learning from Serious Events initiative has not yet commenced. First meeting taking place in March 2019;	1. Q1: Co-design completed 2. Q2: Test of selected improvement ideas completed 3. Q1: Phase 2 High level Design completed. (Timeframe for completion of Detailed Design dependent on MOH process) 4. Q1: Quarterly Reporting Commence	MH *(TBC)* MH02	System outcome We have improved quality of life (health maintenance and independence)	Government priority outcome Support healthier, safer and more connected communities
			System outcome We have improved health equity (healthy populations)	Government priority outcome Make New Zealand the best place in the world to be a child
			System outcome We live longer in good health	Government priority outcome Ensure everyone who is able to, is earning,

			(prevention and early intervention)	learning, caring or volunteering

Addiction • For those DHBs that are not currently meeting the PP8 addiction related waiting times targets (for total population or all population groups), please identify actions to improve performance to support an independent/high quality of life for people with addiction issues. • Please outline the existing and planned AOD services for your region including those for women, Māori and Pacific, older people, opioid substitution and criminal justice clients, ensuring equitable health for all New Zealanders. Please also outline how your DHB will ensure the quality of AOD services to support healthier New Zealanders live an independent and high quality of life. • Noting that mental health and addictions services are a priority for Government please describe how your DHB is giving appropriate priority to meeting service demands within baseline funding. Note: DHBs should take into account both DHB provided services and those that are DHB funded but provided by NGOs.			This is an equitable outcomes action (EOA) focus area (equity focus and clear actions to improve Māori and Pacific Peoples health outcomes)	
DHB activity 1. Review of current AOD NGO services followed by the development of a **3DHB AOD model of care and practice pathway** which will include kaupapa Māori and Pacific therapeutic interventions. The review will address service provision to youth and adults. Where necessary urgent gaps will be appropriately addressed however the intention is to commission new services in 201/21. (EOA) 2. Existing and planned AOD services: MHAIDS provides community alcohol and drug assessment and treatment for adults living in the CCDHB region who have or are concerned they may have moderate to severe mental health and substance use disorders. The MHAIDS Opioid Treatment Service is based in Wellington and provides satellite clinics in Porirua, Kāpiti, Lower Hutt and Upper Hutt.	**Milestone** 1. Q1: Complete AOD MOC framework; Q2: Complete practice pathways; Q3: Develop implementation plan for MOC and PP; Q4: Commissioning of services 2. Q2 and Q4: Non-Financial Reporting	**Measure** MH *(TBC)*	Government theme: Improving the well-being of New Zealanders and their families	
			System outcome We have improved quality of life (health maintenance and independence)	Government priority outcome Support healthier, safer and more connected communities
			System outcome We have improved health equity (healthy populations)	Government priority outcome Make New Zealand the best place in the world to be a child

			System outcome We live longer in good health (prevention and early intervention)	Government priority outcome Ensure everyone who is able to, is earning, learning, caring or volunteering

Maternal mental health services • Informed by the outcome of your 2018/19 stocktake of the primary maternal mental health service provision in your district, and the volumes of women accessing these services, please advise the actions you plan to take in 2019/20 to further improve access and to address any identified issues. Your plans should indicate how equity of access and outcomes for Māori and Pacific women will be addressed and measured.			This is an equitable outcomes action (EOA) focus area (equity focus and clear actions to improve Māori and Pacific Peoples health outcomes)	
DHB activity The stocktake undertaken in 2018/19 showed that we do not fund any primary/community maternal mental health services (apart from a specialist maternal mental health service). 1. Investigate the needs of this population group, prioritise the urgent unmet needs (with a special focus on Maori and Pacific women) and prepare investment bids to commission new services. 2. Review the perinatal, maternal and infant mental health draft strategy with an aim to finalise this strategy by 20/21.	**Milestone** 1. Q1/2: Review community needs, analyse current data and identify urgent gaps; Q3/4: Prepare investment bids for new services 2. Q3/4: Review and finalise strategy in 2020/21	**Measure** MH *(TBC)*	Government theme: Improving the well-being of New Zealanders and their families	
			System outcome We have improved quality of life (health maintenance and independence)	Government priority outcome Support healthier, safer and more connected communities
			System outcome We have improved health equity (healthy populations)	Government priority outcome Make New Zealand the best place in the world to be a child
			System outcome We live longer in good health	Government priority outcome

			(prevention and early intervention)	Ensure everyone who is able to, is earning, learning, caring or volunteering

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2.3.3 Child Wellbeing

Child and youth wellbeing is a priority work programme for Government, the Ministry of Health and District Health Boards. This section identifies annual planning guidance for children and young people that contributes to the development and delivery of New Zealand's first Child and Youth Wellbeing Strategy (the Strategy) and preparing the Health and Disability sector for system transformation over time.

There is an expectation that annual plans reflect how DHBs are actively working to improve the health and wellbeing of infants, children, young people and their whānau with a particular focus on improving equity of outcomes.

Annual plans should inform a comprehensive approach to prevention and early intervention services (primary and community health) provided to women of child bearing age, infants, babies, pre-school and school-aged children and youth and their families/carers.

DHBs should draw on the most relevant information necessary to evidence their approach.

Immunisation

- All DHBs are to contribute to child wellbeing and healthier populations by establishing innovative solutions to improve and maintain high immunisation rates at all childhood milestones from infancy to age 5 years.

For Capital & Coast

- Please provide three specific actions that will increase Māori childhood immunisation coverage levels and sustain high levels at all milestone ages during 2019/20. Please identify how each action will address equity and what outcomes will be achieved.
- Please provide specific actions that will increase and maintain high levels of Pacific childhood immunisation coverage levels and sustain high levels at all milestone ages during 2019/20. Please identify how each action will address equity and what outcomes will be achieved.
- Please provide specific actions that will further strengthen your school-based immunisation programme to better meet the needs of your Pacific and Asian populations.

This is an equitable outcomes action (EOA) focus area

(equity focus and clear actions to improve Māori and Pacific Peoples health outcomes)

DHB activity	**Milestone**	**Measure**	Government theme: Improving the well-being of New Zealanders and their families	
1. Work with PHOs and iwi providers to complete a thorough review of childhood enrolment for CCDHB, to identify interventions to strengthen the relationship between Māori and Pacific families and primary care. (EOA) 2. Work with PHOs, iwi providers and consumers to investigate the reasons for families choosing to decline childhood immunisations, particularly the fluctuating decline rates for Māori families. (EOA) 3. Using the review and investigation data, identify interventions to reduce decline rates for all children, but particularly Māori and Pacific children. (EOA)	1. Q1: Complete review. 2. Q2-4: Implement interventions. 3. Q2: Complete investigation and identify intervention(s). Q3-4 Implement interventions.	CW *(TBC)* CW05 CW08	System outcome We have improved quality of life (health maintenance and independence)	Government priority outcome Support healthier, safer and more connected communities
			System outcome We have improved health equity (healthy populations)	Government priority outcome Make New Zealand the best place in the world to be a child

			System outcome We live longer in good health (prevention and early intervention)	Government priority outcome Ensure everyone who is able to, is earning, learning, caring or volunteering

Supporting Health in Schools *Guidelines for this area will be updated following the results of the 2018/19 stocktake due in quarter two in early 2019.*			This is an equitable outcomes action (EOA) focus area (equity focus and clear actions to improve Māori and Pacific Peoples health outcomes)	
DHB activity *(Placeholder – awaiting further guidance from MoH)*	**Milestone** *TBC*	**Measure** CW *(TBC)* CW10	Government theme: Improving the well-being of New Zealanders and their families	
			System outcome We have improved quality of life (health maintenance and independence)	Government priority outcome Support healthier, safer and more connected communities
			System outcome We have improved health equity (healthy populations)	Government priority outcome Make New Zealand the best place in the world to be a child
			System outcome We live longer in good health	Government priority outcome

			(prevention and early intervention)	Ensure everyone who is able to, is earning, learning, caring or volunteering

School-Based Health Services *To be confirmed in early 2019.*			This is an equitable outcomes action (EOA) focus area (equity focus and clear actions to improve Māori and Pacific Peoples health outcomes)	
DHB activity *(Placeholder – awaiting further guidance from MoH)*	**Milestone** *TBC*	**Measure** CW *(TBC)* CW12	Government theme: Improving the well-being of New Zealanders and their families	
			System outcome We have improved quality of life (health maintenance and independence)	Government priority outcome Support healthier, safer and more connected communities
			System outcome We have improved health equity (healthy populations)	Government priority outcome Make New Zealand the best place in the world to be a child
			System outcome We live longer in good health (prevention and early intervention)	Government priority outcome Ensure everyone who is able to, is earning, learning, caring or volunteering

Midwifery workforce – hospital and LMC

Midwifery workforce:

- All DHBs will develop, implement, and evaluate a midwifery workforce plan to support:
- undergraduate training, including clinical placements
- recruitment and retention of midwives, including looking at driving changes for models of care that use the full range of the midwifery workforce within DHBs
- service delivery mechanisms that make best use of other health work forces to support both midwives in their roles and pregnant people.
- DHBs who were asked to develop midwifery workforce plans as part of the 2018/19 annual planning cycle are expected to continue working on midwifery workforce plans if this has not been completed during the 2018/19 year.

This is an equitable outcomes action (EOA) focus area

(equity focus and clear actions to improve Māori and Pacific Peoples health outcomes)

Examples of equity actions that could be included in your plan:

1. increase Māori participation and retention in midwifery workforces and ensure that Māori have equitable access to training opportunities as others
2. build cultural competence across the whole midwifery workforce
3. increase participation of Pacific people in midwifery workforces
4. form alliances with educational institutes (including secondary and tertiary) and local iwi to identify and implement best practices to achieve Māori midwifery workforces that matches the proportion of Māori in the population.

DHB activity	**Milestone**	**Measure**	Government theme: Improving the well-being of New Zealanders and their families	
1. Develop a Midwifery Workforce Strategy 2. Partner with Victoria University to support a new midwifery training program, for potential commencement in 2020. The program is proposed to be over four years and will provide more flexibility for students which will potentially make training possible for more Māori and Pacific students. (EOA)	1. Q3: Strategy Developed. 2. Q1: Victoria University decision on implementation,	CW *(TBC)*	System outcome We have improved quality of life (health maintenance and independence)	Government priority outcome Support healthier, safer and more connected communities

3. Explore the potential to use a Dedicated Education Unit model to support student midwives including requesting specific support for Māori and Pacific learners from Tertiary Education Provider. (EOA) 4. Re-establish and strengthen midwifery connection to Kia Ora Hauora to maximise recruitment of Māori and Pacific students. (EOA)	Q3. Commence implementation. 3. Q3: Dedicated Education Unit model Explored. 4. Q2: Connections Re-Established.		System outcome We have improved health equity (healthy populations)	Government priority outcome Make New Zealand the best place in the world to be a child
			System outcome We live longer in good health (prevention and early intervention)	Government priority outcome Ensure everyone who is able to, is earning, learning, caring or volunteering

First 1000 days (conception to around 2 years of age)

- Identify the most important focus areas to ensuring the population needs for pregnant women, babies, children and their whānau are well understood; and identify key actions that demonstrate how the DHB will meet these needs including realising a measurable improvement in equity for your DHB. Actions should include a comprehensive approach to prevention and early intervention services across priorities (see below) via maternity, Well Child Tamariki Ora, National SUDI Prevention Programme, and other services.
- Identify what action you will take to identify barriers to achieving well integrated services across the first 1000 days.

Healthy weight in children

- Identify the actions the DHB is taking to increase the proportion of children at a healthy weight in their first 1000 days.

This is an equitable outcomes action (EOA) focus area

(equity focus and clear actions to improve Māori and Pacific Peoples health outcomes)

DHB activity	**Milestone**	**Measure**	Government theme: Improving the well-being of New Zealanders and their families	
1. Continue to scale an integrated Mama Pepi Tamariki model in Porirua, focusing on whānau-centric, community-led holistic support for Māori hāpu mama and their whānau and Pacific mothers, babies and families.	1. Q1 – Q3 2. Q4 3. Q1 – 4	CW *(TBC)* CW06	System outcome We have improved quality of life	Government priority outcome

2. Evaluation of the first 6 months of the integrated Mama Pepi Tamariki model. 3. Establish and coordinate up to three Maternal and Child Wellbeing stakeholder group hui, with a view to support better connection, information sharing and training between secondary, primary, community and NGO/charitable partners. *4. Breastfeeding action under development*	4. TBC		(health maintenance and independence)	Support healthier, safer and more connected communities
			System outcome We have improved health equity (healthy populations)	Government priority outcome Make New Zealand the best place in the world to be a child
			System outcome We live longer in good health (prevention and early intervention)	Government priority outcome Ensure everyone who is able to, is earning, learning, caring or volunteering

Family Violence and Sexual Violence (FVSV) Reducing family violence and sexual violence is an important priority for the Government, and something we want all DHBs to be working on, in partnership with communities and other agencies. Please provide the actions for the upcoming year that your DHB considers is the most important contribution to this, including the reasons why the action(s) are important and the impact you expect them to achieve.			This is an equitable outcomes action (EOA) focus area (equity focus and clear actions to improve Māori and Pacific Peoples health outcomes)	
DHB activity	**Milestone**	**Measure**	Government theme: Improving the well-being of New Zealanders and their families	
1. Progress a strategic data sharing project with key partner agencies (including Police and Plunket), with a view to identity targeted improvement interventions that better support Māori, Pacific and families living in areas of high deprivation	1. Q2: Identify improvement interventions 2. Q1-4: 60% of clinicians completed VIP training	CW *(TBC)* CW11	System outcome We have improved quality of life (health maintenance and independence)	Government priority outcome Support healthier, safer and more connected communities

2. Continue the roll out of Violence Intervention Programme (VIP) training to DHB clinicians (medical, nursing and allied health) in priority services[2] 3. Increase Routine Enquiry relating to Intimate Partner Violence (IPV) for eligible patients presenting to priority services as outlined below: a. 35% Emergency Department b. 50% Children's Health c. 80% Women's Health, Community Mental Health, Addictions Service 4. Increase disclosure rates (associated with Routine Enquiry) to at least 5% in the priority services. 5. Increase the use of the Injury Flow Chart relating to Child Abuse and Neglect for eligible patients (children <2 years old) presenting to Emergency Department to 85%	3. Q1-4: Eligible patients will be subject to Routine Enquiry 4. Q1-4: Increase Routine Enquiry disclosure rate to >5% 5. Q1-4: 85% of children <2 years presenting to ED will have an Injury Flow Chart completed		System outcome We have improved health equity (healthy populations)	Government priority outcome Make New Zealand the best place in the world to be a child
			System outcome We live longer in good health (prevention and early intervention)	Government priority outcome Ensure everyone who is able to, is earning, learning, caring or volunteering

SUDI • Describe contributions towards building stronger working relationships across the Maternal and Child Health sector to address the key modifiable risks factors for SUDI			This is an equitable outcomes action (EOA) focus area (equity focus and clear actions to improve Māori and Pacific Peoples health outcomes)	
DHB activity	**Milestone**	**Measure**	Government theme: Improving the well-being of New Zealanders and their families	
1. Implement and monitor a safe sleep device programme across CCDHB. This programme will provide free safe sleep devices (including pepi pods and wahakura) to women with two or more of the following risk factors: a. Pacific or Māori babies b. Smoke exposed baby (in pregnancy and/or in the home)	1. Q1 – Q4 2. Q3 – Q4	CW *(TBC)* CW09	System outcome We have improved quality of life (health maintenance and independence)	Government priority outcome Support healthier, safer and more connected communities

[2] Emergency Department, Women's Health, Children's Health, Community Mental Health, Addictions Services

c. Other biological or environmental concerns identified by clinical teams (e.g. prematurity, co-sleeping, etc) 2. Implement wahakura wānanga programmes to vulnerable hāpu mama and whānau, including focused messages around safe sleep, immunisation, breastfeeding and smoking cessation			System outcome We have improved health equity (healthy populations)	Government priority outcome Make New Zealand the best place in the world to be a child
			System outcome We live longer in good health (prevention and early intervention)	Government priority outcome Ensure everyone who is able to, is earning, learning, caring or volunteering

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2.3.4 Primary health care

Primary health care is a priority work programme for Government, the Ministry of Health and District Health Boards.

An affordable effective primary care system is essential to achieving the objectives of a strong public health system. Primary care is the means through which the health system can decrease use of expensive secondary health services, better manage and lower the incidence of long-term conditions, increase use of illness-preventing behaviours and treatments, and thereby increase people's ability to participate in work and education.

Primary health care is earlier, safer, cheaper, and better connected to people's daily routines.

However, the primary health care system does not serve all people equitably. Some people are avoiding or delaying engaging with primary care services because of cost. There is also the potential for a different primary care model to better suit people's lives and better integrate across health disciplines and facilities, thereby improving health outcomes.

Primary health care integration

DHBs are expected to continue to work with their district alliances on integration including (but not limited to):

- strengthening their alliance (e.g., appointing an independent chair, establishing an alliance programme office, expanding the funding currently considered by the alliance)
- broadening the membership of their alliance (e.g., pharmacy, maternity, public health, WCTO providers, mental health providers, ambulance)
- developing services, based on robust analytics, that reconfigure current services and address equity gaps

In addition, please identify actions you are undertaking in the 2019/20 year to:

- assist in the utilisation of other workforces in primary health care settings
- this section will be finalised when final Government decisions are made. However all DHBs are expected to describe at least one action they are taking with their primary care partners that improves access to primary care services, particularly for high needs patients.

Note: Some or all of the actions in this section may form part of your System Level Measure Improvement Plan. If this is the case it is not necessary to provide that information here but rather indicate that the assessor should refer to the SLM Improvement Plan.

This is an equitable outcomes action (EOA) focus area

(equity focus and clear actions to improve Māori and Pacific Peoples health outcomes)

DHB activity	**Milestone**	**Measure**	Government theme: Improving the well-being of New Zealanders and their families	
CCDHB has a strong Alliance know as our Integrated Care Collaborative. This ICC is fully supported by an ICC team at CCDHB. A full range of membership is present across the ICC groups that contribute to the development of our primary care and Community Health Network strategy. 1. CCDHB will continue to strengthen the Alliance relationships, broaden membership and develop services based on robust data and analytics. 2. CCDHB is focused on improving Maori enrolment in primary care, particularly young people in Porirua where the most significant gap is identified.	Q1-4: SLM Reporting Q2 Action Plan Developed	PH *(TBC)* PH01 PH03	System outcome We have improved quality of life (health maintenance and independence)	Government priority outcome Support healthier, safer and more connected communities
			System outcome	Government priority outcome

3. The SLM Improvement Plan has a strong equity focus – the plan will identity equity targets and actions to improve health outcomes for those populations (EOA). 4. Primary health care workforce (TBC)			We have improved health equity (healthy populations)	Make New Zealand the best place in the world to be a child
			System outcome We live longer in good health (prevention and early intervention)	Government priority outcome Ensure everyone who is able to, is earning, learning, caring or volunteering

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<table>
<tr><td colspan="3">Pharmacy
• Continue to support the vision of the Pharmacy Action Plan and the Integrated Community Pharmacy Services Agreement (ICPSA) by working with pharmacists, the public, primary care and the wider health care team to commission integrated local services that prioritise local need and support equitable health outcomes.
• Support the work to enable the separation of dispensing into separate ICPSA schedules (medicine and supply and clinical advice) by June 2020.
• Develop local strategies that support pharmacy and other immunisation providers to work together to improve influenza vaccination rates in Māori, Pacific and Asian people over 65 years of age.
• We recommend that you work with your district alliance System Level Measure (SLM) team(s) to investigate if influenza vaccination rates for those populations should be part of the SLM Improvement Plan. In particular those working groups developing actions for the ASH for 0-4year olds, Acute hospital bed days and Patient experience of care SLMs. If the vaccination rates of these populations are seen to impact any of these SLMs, specific actions to improve influenza rates could be part of your SLM Improvement Plan.</td><td colspan="3">This is an equitable outcomes action (EOA) focus area
(equity focus and clear actions to improve Māori and Pacific Peoples health outcomes)</td></tr>
<tr><td>DHB activity

1. The major focus of new Pharmacy investment within CCDHB through Community Pharmacies, and of Pharmacy Facilitation services, will be activities in areas of both high deprivation and high Māori and Pacifica populations. Specifically:
a. Community Pharmacy based Gout management services in selected Porirua Pharmacies. We will invest in community pharmacies with high Māori and Pacifica populations to support the population with high number of Gout sufferers (Māori and Pacific). (EOA)
b. Community Pharmacy ECP service with funding to be based on pharmacies whose clients have high rates of teenage pregnancies. Review current Pharmacy Facilitation Service</td><td>Milestone

1. (a) Q2: service established;
(b) Q1: service reviewed
2. TBC
3. Q1: Publicity material released
4. Q2: Review performed; Q3: New contracts issued</td><td>Measure

PH (TBC)</td><td colspan="3">Government theme:
Improving the well-being of New Zealanders and their families</td></tr>
<tr><td colspan="3"></td><td>System outcome
We have improved quality of life
(health maintenance and independence)</td><td>Government priority outcome
Support healthier, safer and more connected communities</td></tr>
<tr><td colspan="3"></td><td>System outcome
We have improved health equity
(healthy populations)</td><td>Government priority outcome
Make New Zealand the best place in the world to be a child</td></tr>
</table>

2. Dependant on funding- invest in a new clinical pharmacist in low-decile practices with high numbers of Māori and Pacific. (EOA) 3. Continue to support Pharmacies to deliver immunisation. Use web based publicity and signage within the community to inform the public about subsidised immunisation. 4. Review CPAMS service Develop and use new criteria focusing on equity to select pharmacies to provide this service (funding will be within baseline pharmacy budget). Equity for Māori and Pacific Peoples will be a consideration when contracting these services. (EOA)			System outcome We live longer in good health (prevention and early intervention)	Government priority outcome Ensure everyone who is able to, is earning, learning, caring or volunteering

Smokefree 2025 • Identify activities that advance progress towards the Smokefree 2025 goal, including supporting Ministry funded wrap-around stop smoking services for people who want to stop smoking and which address the needs of hāpu wāhine and Māori.			This is an equitable outcomes action (EOA) focus area (equity focus and clear actions to improve Māori and Pacific Peoples health outcomes)	
DHB activity 1. Refresh and implement the DHB Tobacco Control Plan for 2019-2021 focusing on integration of services and support for hāpu wāhine, Māori, and Pacific peoples. 2. Develop an action plan for young Maori, and persistent smokers, to reduce smoking rates in this cohort. 3. Expand the Hāpu Mama incentives programme to support 100 Māori and Pacific mothers of children aged 0-4 years to quit smoking. 4. Ongoing monitoring and support for Well Child Tamariki Ora providers to embed data recording and collection to support the *Percentage of babies living in smokefree homes at 6 weeks* SLM 5. Maintain a programme of continuous quality improvement initiatives to support achievement of the Better Help for Smokers to Quit targets, including equity for Māori and Pacific.	**Milestone** 1. Q1: Plan approved 2. Q3 Action Plan Developed 3.Q4: Support 100 mothers in 2019/20 4. SLM Reporting 5. Q1-4: Achievement of all three targets	**Measure** PH *(TBC)* PH04	Government theme: Improving the well-being of New Zealanders and their families	
			System outcome We have improved quality of life (health maintenance and independence)	Government priority outcome Support healthier, safer and more connected communities
			System outcome We have improved health equity (healthy populations)	Government priority outcome Make New Zealand the best place in the world to be a child
			System outcome	Government priority outcome

			We live longer in good health (prevention and early intervention)	Ensure everyone who is able to, is earning, learning, caring or volunteering

Diabetes and other long-term conditions

- Identify the most significant actions the DHB will take across the sector to strengthen public health promotion to focus on the prevention of diabetes and other long term conditions.
- Identify how the DHB will ensure all people with diabetes will have equitable access to culturally appropriate self-management education and support services.
- Monitor PHO/practice level data to improve equitable service provision and inform quality improvement.

This is an equitable outcomes action (EOA) focus area
(equity focus and clear actions to improve Māori and Pacific Peoples health outcomes)

DHB activity	**Milestone**	**Measure**	Government theme: Improving the well-being of New Zealanders and their families	
1. Development of community health network based support for people to live healthy lifestyles. This will be an integrated programme of peer support, health coaches, exercise programmes, behavioural change support and nutrition advice. It will be piloted in one of our localities. Budget dependent (EOA) 2. The DHB will assess equitable access to culturally appropriate self-management education and support services as part of the Q2 2019/20 self-assessment against the Quality Standards for Diabetes care. Identified gaps will be remedied in Q3/4 in partnership with our PHOs who deliver the self-management education. (EOA) 3. Improve the outcomes for people diagnosed with type 2 diabetes at a young age (with a focus on Māori and Pacific Peoples aged 25-39 years)	1. Q2: Self-assessment; Q3 and 4: Change management 2. Q2 and 4: Report on the success of targeted initiatives to tailor intensive diabetes care to individuals and families.	PH *(TBC)*	System outcome We have improved quality of life (health maintenance and independence)	Government priority outcome Support healthier, safer and more connected communities
			System outcome We have improved health equity (healthy populations)	Government priority outcome Make New Zealand the best place in the world to be a child

by tailoring interventions for young people and their families. Report on the success of targeted initiatives. (EOA)	3. Q4: Reduce number of Māori and Pacific Peoples with an HBA1C greater than 64mmol/mol by 4%		System outcome We live longer in good health (prevention and early intervention)	Government priority outcome Ensure everyone who is able to, is earning, learning, caring or volunteering

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2.3.5 Environmental sustainability and drinking water safety

This priority work programme is aligned with several of Government's priority outcomes, including: Transition to a clean, green carbon neutral new Zealand; Grow and share New Zealand's prosperity more fairly.

DHBs are expected to continue to contribute to the Government's priority outcome of environmental sustainability including reducing carbon emissions, to address the impacts of climate change on health.

Climate change has been described as the "biggest global health threat" and "greatest global health opportunity" of the 21st century. While tackling climate change will require intersectoral action across New Zealand society and Government, the health sector has a large role to play in supporting and encouraging climate action.

The Government is undertaking system-wide reform of the regulatory arrangements for drinking water and DHBs are expected to support any developments that may result. DHBs are expected to work through their public health units and across agency and legislative boundaries to carry out their key role in drinking water safety with a focus on the health of the population.

Climate change

This work is a continuation of the climate change and waste disposal planning priorities from the Annual Plan Guidelines 2018/19, and is aligned with the Government's priority outcome of environmental sustainability. It is also related to the priority outcome of a strong public health system.

- Identify and undertake further areas for action (for example, via gaps identified in the 2018/19 stocktake of climate change actions) to positively mitigate or adapt to the effects of climate change and their impacts on health. Where appropriate and able, these should be underpinned by cost-benefit analysis of co-benefits and financial savings.
- As appropriate, identify actions that improve the use of environmental sustainability criteria in procurement processes

<table>
<tr><th>DHB activity</th><th>Milestone</th><th>Measure</th><th colspan="2">Government themes:
Improving the well-being of New Zealanders and their families
Build a productive, sustainable and inclusive economy (priority outcome is: Transition to a Clean, Green and Carbon Neutral New Zealand)</th></tr>
<tr><td rowspan="3">1. CCDHB will undergo the second independently audited carbon footprint measure (as identified in the 2018/19 stocktake). Benchmarking has been carried out in Q3 of 2018/19.</td><td rowspan="3">Q3 - CEMARS audit completed
(% reduction in CO2 emissions from 2018 benchmark)</td><td rowspan="3">PE (TBC)</td><td>System outcome
We have improved quality of life
(health maintenance and independence)</td><td>Government priority outcome
Transition to a clean, green carbon neutral new Zealand</td></tr>
<tr><td>System outcome
We have improved health equity
(healthy populations)</td><td></td></tr>
</table>

<table>
<tr><td colspan="2"></td><td></td><td>System outcome
We live longer in good health
(prevention and early intervention)</td><td></td></tr>
<tr><td colspan="5">Waste disposal
This work is a continuation of the climate change and waste disposal planning priorities from the Annual Plan Guidelines 2018/19, and is aligned with the Government's priority outcome of environmental sustainability. It is also related to the priority outcome of a strong public health system.
• Identify further areas for action (for example, via gaps identified in the 2018/19 stocktake of waste disposal actions) to support the environmental disposal of hospital and community (e.g., pharmacy) waste products (including cytotoxic waste).</td></tr>
<tr><td>DHB activity

1. Continue to raise public awareness of their ability to return unused medicines to community pharmacies so that disposal of them can be performed in a safe manner. Posters will be published in Community Pharmacies encouraging clients to return waste medicine.</td><td>Milestone

Q2: Posters send to pharmacies and other points to display.</td><td>Measure

PE (TBC)</td><td colspan="2">Government themes:
Improving the well-being of New Zealanders and their families
Build a productive, sustainable and inclusive economy (priority outcome is: Transition to a Clean, Green and Carbon Neutral New Zealand)</td></tr>
<tr><td colspan="3" rowspan="3"></td><td>System outcome
We have improved quality of life
(health maintenance and independence)</td><td>Government priority outcome
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<tr><td>System outcome
We have improved health equity
(healthy populations)</td><td></td></tr>
</table>

			System outcome We live longer in good health (prevention and early intervention)	

Drinking water **Provide actions the DHB will undertake to support their PHU to deliver and report on the drinking water activities in the environmental health exemplar.**			This is an equitable outcomes action (EOA) focus area (equity focus and clear actions to improve Māori and Pacific Peoples health outcomes)	
DHB activity 1. Identify and investigate incidents, complaints and notifications of adverse drinking water quality (or adequacy) of networked, tankered and temporary drinking water supplies.(EOA) 2. Promote compliance with the drinking-water requirements of the Health Act 1956 and achievement of the Drinking-Water Standards for New Zealand to drinking-water suppliers and water carriers, and undertake compliance and enforcement action as required.(EOA)	**Milestone** 1. Q4: report on the number of investigations completed, per DHB 2. Q4: percentage of networked water suppliers serving more than 100 people with approved water safety plans, per DHB.	**Measure** PE *(TBC)*	Government theme: Improving the well-being of New Zealanders and their families	
			System outcome We have improved quality of life (health maintenance and independence)	Government priority outcome Grow and share New Zealand's prosperity more fairly
			System outcome We have improved health equity (healthy populations)	
			System outcome We live longer in good health (prevention and early intervention)	

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2.4 Financial performance summary

This section needs to include the consolidated statement of comprehensive income (previous year's actual, current year's forecast and three years plan), and the prospective summary of revenue and expenses by output class for the next three years.

(Placeholder for Financial Performance Tables – pending release of the Funding Envelope)

SECTION THREE: Service Configuration

3.1 Service Coverage

All DHBs are required to deliver a minimum of services, as defined in The Service Coverage Schedule, which is incorporated as part of the Crown Funding Agreement under section 10 of the New Zealand Public Health and Disability Act 2000, and is updated annually. Responsibility for service coverage is shared between DHBs and the Ministry. DHBs are responsible for taking appropriate action to ensure that service coverage is delivered for their population, including populations that may have high or different needs such as Māori, Pacific Peoples and high-needs groups.

CCDHB may, pursuant to section 25 of the New Zealand Public Health and Disability Act 2000, negotiate and enter into, or amend any current agreement for the provision or procurement of services. CCDHB is not seeking any formal exemptions to the Service Coverage Schedule in 2019/20.

3.2 Service Change

The table below describes all service changes that have been approved for implementation at CCDHB in 2019/20. Sub-regional service changes that do not affect the CCDHB domiciled population are excluded.

Summary of Service Changes for 2019/20:

Change	Description of Change	Benefits of Change	Change for local, regional or national reasons
Vascular Service	We will be implementing non-contact FSA and follow up	Easier access for patients particularly from outside Wellington. Less travel, expense of travel.	Regional
Ophthalmology service	Implementation of national AMD and glaucoma referral guidelines	Nationally consistent acceptance criteria, consistent timeframes for review and follow up	Sub-regional
Renal Services	We will explore how the DHB might better meet the needs of the HVDHB community by exploring a dialysis unit in the Hutt Valley.	Improved access, reduced cost, improvement of patients on long term dialysis.	Sub-regional
Community Pharmacist Services	Implement HVDHB's Pharmacists Services Strategy, which includes reviewing the Long Term Condition service provided by pharmacists, and the commissioning of pharmacist services to aged residential care.	More integration across the primary care team Improved access to pharmacist services Consumer empowerment Safe supply of medicines to the consumer Improved support for at-risk populations More use of pharmacists as a first point of contact within primary care.	Sub-regional

Inpatient mental health services models of care (3DHB)	Following significant issues with the physical space of our Te Whare Ahuru mental health inpatient unit, the DHB has embarked on a strategic assessment and single stage business case to consider facility options.	Improved health outcomes Improved patient experience Improved responsiveness to Māori health	Sub-regional
Acute mental health services and alcohol and other drug treatment services	The DHBs are undertaking a review of their mental health acute services and alcohol and other drug treatment services. This may result in commissioning a different range of services that what is currently funded. It may also result in the termination of some current agreements to allow the commissioning of best practice model-of-care services that support optimal population health outcomes.	Improved health outcomes Improved patient experience Improved responsiveness to Māori health Value for money	Sub-regional
Sub-regional clinical services planning	As part of the sub-regional hospital network programme, CCDHB and HVDHB will be reviewing the delivery of the following services: Breast Services, Oncology services, Renal Dialysis Services, Gastroenterology/Colonoscopy, Ear, Nose and Throat, Cardiology, and Ophthalmology services.	Improved population health outcomes Maintain the financial sustainability of the services Value for money	CCDHB and Hutt Valley DHB
Bowel Screening	CCDHB is planning to implement the National bowel screening programme in March 2020	Bowel Screening aims to reduce the mortality rate from bowel cancer by diagnosing and treating bowel cancer at an early curable stage, as well as identifying and removing pre-cancerous adenomas from the bowel before they become cancerous.	Local

SECTION FOUR: Stewardship

4.1 Managing our Business

Organisational performance management

CCDHB's performance is assessed on both financial and non-financial measures. Internally, performance is presented to the Executive Leadership Team (ELT), Clinical Council, Māori Partnership Board (MPB), Sub-Regional Pacific Strategic Health Group (SRPSHG), Sub-Regional Disability Advisory Group (SRDAG), the Health System Committee (HSC), 3DHB Disability Support Advisory Group (DSAC), Finance and Risk Assessment Committee (FRAC), and the Board. CCDHB reports to the Ministry on a quarterly, six-monthly or annual basis.

Funding and financial management

CCDHB's key financial indicators are spend against budget and budget against deficit. These are assessed against and reported through CCDHB's performance management process to the ELT and the Finance and Risk Assessment Committee (FRAC).

Investment and asset management

CCDHB is committed to a sustainability pathway (CCDHB Even Better Health Care) that emphasises cross-organisation and system governance of financial and service delivery performance. It is supported by an Investment Approach that considers all investments across the health system, and determines their impact on the optimisation of the system. Part of the work programme is the development of whole of system investment plans, capital investment, infrastructure development and service investment strategies as reflected in the Long Term Investment Plan (LTIP) currently being updated.

CCDHB and Hutt Valley DHB have entered into a joint sub-regional clinical planning process. CCDHB will deliver an LTIP by July 2019 to meet Treasury requirements, with a joint LTIP (CCDHB and HVDHB) to be delivered by July 2020. The joint hospital network planning work programme is an input into CCDHB's LTIP for 2019, and will inform the joint LTIP in 2020. The LTIP will inform 'what' investments are needed to implement the strategic vision and associated strategies of CCDHB and HVDHB. These investments have to deliver on ensuring the safety and quality of our services, the impact on equity and outcomes amongst our populations and the sustainability of our health system.

Shared service arrangements and ownership interests

CCDHB has a part ownership interest in Central Region Technical Advisory Service (CRTAS), the Regional Health Information Partnership (RHIP), Allied Linen Services Ltd (ALSL) and New Zealand Health Partnerships (NZHP). The DHB does not intend to acquire interests in companies, trusts or partnerships.

Risk management

The CCDHB Risk Management Framework provides principles and process to ensure CCDHB is operating in accordance with the 2008 Health and Disability Service Standards, the AS/NZS ISO 31000:2009 standard for Risk Management and the Health and Safety at Work Act 2015 and associated regulations.

Health and Safety (H&S) is a particular focus across the DHB. Accountability for H&S is the responsibility of every manager and employee. Systems for managing H&S risk are deployed across the organisation.

The Finance, Risk & Audit Committee (FRAC) of the CCDHB Board has oversight of internal controls (including risk management) and is focussed on financial and contractual matters of significance.

The DHB has established external and internal Audit functions which provide independent professional assessments of key risks, the accuracy and integrity of CCDHB financial reports and the adequacy of internal controls. We are progressing improvement plans for the Treasury Investor Confidence Rating.

Quality assurance and improvement

Clinical Governance is the system by which the governing body, managers, clinicians and staff share responsibility and accountability for the quality of care, continuously improving, minimising risks, and fostering an environment of excellence in care for consumers/patients/residents.[3] A shared commitment is required from all clinical and non-clinical staff to provide high quality and safe care, and organisational support from board to the ward.

The CCDHB Clinical Governance Framework has recently been updated. This framework aims to bring individual elements together to strengthen and sustain ongoing improvement around the six dimensions of quality; safe, timely, equitable, effective, efficient and people centred (STEEEP).

CCDHB's clinical governance framework has four components[4]. These are:

- consumer engagement and participation
- clinical effectiveness
- quality improvement and patient safety
- engaged effective workforce

They provide a structure to implement strategies to improve and enhance the quality of care.

4.2 Building Capability

Capital and infrastructure development

CCDHB has a significant investment in capital assets particularly property, ICT and clinical equipment. Our plans for capital investment are outlined in our Asset Management Plan. Key activities include:

- The development of Asset Management Plans including clinical equipment and facilities, and a Master Site Plan for all CCDHB facilities. Deferred maintenance of facilities and equipment is a key component of these planning processes.
- CCDHB has a number of older properties which are not suitable for use. Options for these properties are being considered. CCDHB has significant property assets with poor utilisation due to historical design. Options are being investigated to improve utilisation.
- The Wellington Regional Hospital domestic hot and cold water systems are exhibiting signs of failure. Remediation plans are being developed to support a business case resolve this issue.
- A project to build a new Children's Hospital is in progress due to the generosity of a benefactor who has offered a $50 million contribution including design and construction management. Total project budget of $105 million includes relocation of existing services, the replacement of sewage and storm water pipes and demolition of old buildings.
- Development of a six bed facility/extension to Haumietiketike, the National Intellectual Disability Inpatient Unit, has been approved by the Minister. The projected capital cost of the six bed unit is $8.4m. This includes all costs of construction for the Individualised Specialised Units extension to Haumietiketike.
- Maturity of asset management planning is improving following a review, which was an element of the Treasury ICR review in 2017. Three separate streams of work are in progress for each: ICT, clinical equipment and facilities. Another ICR review is planned for 2019.

[3] National model Clinical Governance Framework. Australian Commission on safety and Quality in Healthcare. Nov 2017

[4] Clinical Governance Guidance for Health and Disability Providers. Health Quality and safety Commission. Feb 2017

Information technology and communications systems

Information and Communication Technology (ICT) can improve efficiency, quality and safety of services, improve care in the community, reduce avoidable demand for emergency and inpatient care in the DHB's provider arm and manage resources more efficiently.

We have identified focus areas for strategic investment to deliver a step change in our ability to create and operate models of care that fundamentally changes our current trajectory:

Digital & Mobile Inpatient Care

Mobility in the community

Integrating whole system of care

The Engine (ICT Platforms & Delivery Model)

These are not the only ICT investments. Investment needs to balance transformational and operational need. There will be linkages to key programmes and projects to maximise the potential benefits of the investments being made and avoid poor investment choice.

In addition to the key investments we are making in line with the focus areas (detailed in the Data & Digital section of the Annual Plan), ICT are also undertaking key initiatives to improve its capacity and capability to deliver including:

- Completing its Future State Enterprise Architecture and key systems roadmaps including Infrastructure, Digital Imaging, Office 365, Electronic Health Record and Patient Administration System;
- Automating a number of routine, manually intensive tasks including testing and account creation to release additional capacity to meet increased demand;
- Establishing customer engagement pathways that are visible to provide our stakeholders with clear points of entry and service level expectations;
- Implementing Application Portfolio Management for our top 10 systems;
- Establishing more agile, product based teams to improve the effectiveness of our delivery to key priorities; and
- Establishing a dedicated security team to improve the IT security of our key systems and information assets.

Workforce

CCDHB strives to be a good employer and is aware of our legal and ethical obligations. We are aware that good employment practices are critical to attracting and retaining top health professionals and support staff who embody our values and culture in their practice and contribution to organisational life.

We recognise the aims, aspirations, cultural differences and employment requirements of Māori people, Pacific Peoples and people from other ethnic or minority groups. We will prioritise a range of strategies with a particular focus on the recruitment and retention of Māori and Pacific staff. We will provide opportunities for individual employee development and career advancement, including cultural competency training.

CCDHB's People Strategy has the following principles and strategic intent:

Principle	Strategic Intent
Strong foundations	Invest in the fundamental building blocks that ensure our people have the skills and tools to excel and to lift health outcomes for our whole population, with a focus on Māori and Pacific Peoples.
Trust and partnership	Support open respectful communication, shared decision making, easy processes, transparency and individual accountability.
Promoting wellbeing	Work together for the health and wellbeing of our people and the community we serve.

Learning from excellence	Foster innovation to ensure we do more of what we do well. Recognise the efforts and contribution of individuals, teams, leaders and managers.

Equity

Finalisation of Taurite Ora, the Māori Health Strategy and the development of the Māori Action Plan in late 2018-19 signals CCDHB's intention to make significant progress towards becoming a pro-equity organisation. Workforce initiatives are, and will remain, central to these initiatives.

Developing models of care and commissioning services that improve equity. This includes services within our communities, building on our locality based planning; services in our community health networks and our specialty services.

Measuring the system performance of all services is a priority to identify whether who you are, and where you live has an impact on your potential health and wellbeing. This includes analysing how people access services, whether they remain in appropriate care pathways, and whether they achieve the expected health outcomes.

Improving CCDHB's systems to allow for the collation of accurate data about the ethnic backgrounds of all employees, and particularly Māori people, and Pacific People will be a priority in 2019-20. This work will address long-run workforce system challenges and see the collection of ethnicity, and other, employee-related data standardised and rationalised across CCDHB's workforce systems. The ongoing implementation of the business information tool Qlik will allow for improved and wider access to, and use of, this data.

Workforce priorities will focus on improving the effectiveness and appropriateness of CCDHB's attraction, recruitment and retention of employees from different ethnic groups, with a particular focus on Māori people, and Pacific People. These efforts will support the intention of having a workforce that is more reflective of the populations we serve.

Recognising that all employees have a role to play in providing a safe and supportive health care environment to our priority populations, there will be an increased focus on providing staff from across CCDHB with development and support in growing their understanding and improving their application of the principles of Te Tiriti o Waitangi; improving their Te Reo; and growing their cultural competence.

Staff Wellbeing

With the focus in 2018-19 on development of CCDHB's Wellbeing Framework and Programme, the focus in 2019-20 will be on implementation of the Programme.

The year will begin with completion of strategy development for specific wellbeing priority areas e.g. fatigue relating to shift work and rostering, staff experiencing domestic violence, staff experiencing trauma potential incidents at work, low paid workforces.

It will progress to focus on mental health, with the aim of strengthening the 2018 campaign of utilising the Mental Health Foundation's 5 Ways to Wellbeing as a basis. The year will conclude with development of a strategy regarding diversity, inclusion, identity and belonging.

The particular needs of Māori and Pacifica employees are a high priority within this work.

Diversity

The diversity of our workforce needs to reflect the communities we serve. Specific strategies to attract, recruit and retain our Maori, Pacific and Disability workforce are present in all of these strategies.

We will continue to build our understanding of our workforce through better use of workforce data, and ongoing use of survey tools. We will continue to develop our ability to integrate workforce intelligence and utilise forecasting tools.

We will also continue to build the capability of our new graduates through our commitment to workforce initiatives and high quality training for groups such as RMO Postgraduate Year 1 and 2 (PGY 1's and 2's); our New Entry to Specialist Practice programme for nursing; and the development of a programme to improve the support for allied health, technical and scientific graduates and trainees.

Health Literacy and Communication

In developing a programme focused on building effective healthcare worker communication, the following questions, which are taken from the 6 Dimensions of a Health Literate Organisation (Ministry of Health) will be considered

1. How will we encourage and support our workforce to develop effective health literacy practices?
2. How will we continue to identify our workforces' development and capacity needs?

In 2019 a plan based on the principles of health literacy will be developed, specifically answering the two questions above. We have identified the communication capabilities for our workforce and audited our current learning offerings. The implementation of the plan will follow throughout the year.

DHB Workforce Priorities

CCDHB will focus on the following workforce priorities during the 2019-20 year:

Values - 2019-20 will see us launching and embedding values resulting from co-design work to be undertaken in early 2019. In the first half of the year this will involve the confirmation and launch of the organisation's revised values, which will be followed by confirmation of values based behaviours and communicate to support application of the new values at both individual and team levels. In the second half of the year the new values will be embedded in CCDHB's systems, processes, policies and activities. Connections will also be made with the development of strategy for diversity and inclusion, identity and belonging.

Leadership - We will continue with our existing offerings of the Frontline Leadership Programme, Emerging Leaders and Manage Well. In 2019-20 these offerings will be complemented with a Clinical Leadership Programme and refreshed Orientation.

Leaders as Coaches will be our main focus of development to support our organisation culture work. It will have two threads - leader to team member coaching and peer to peer coaching. It will consist of course participation, online learning, and simulation exercises.

A leadership series will be developed for AHS&T and Nursing leadership to support the development plans for these workforces. The leadership series will be comprised of short workshops where the priorities of the organisation, including dialogue about equity, will be discussed and made real.

Supporting Safety Culture - 2019-2020 is the second year of our three year Supporting Safety Culture Programme, and will build on the significant progress made throughout the 2018-19 year.

In the first half of 2019-20 CCDHB will introduce and implement a response mechanism for unwarranted behaviours, with the focus on promoting professional accountability.

Following on from the 2018 implementation of the Safety Attitudes Questionnaire (SAQ), a further SAQ survey will take place to assess the effectiveness of the Supporting Safety Culture programme in building a strong safety culture.

The 2019-20 year will conclude with a review of the Supporting Safety Culture programme to ensure appropriate priorities are identified for the third year of the programme in the 2020-21 year.

Co-operative developments

CCDHB is developing its approach to health and social service integration using a localities approach to working with communities, NGOs, PHOs, charitable organisations and health and social service agencies. This locality approach is commencing in Porirua and in the support of young people with mental health needs.

CCDHB provides services to the populations of Hutt Valley and the wider central region. CCDHB and HVDHB serve populations that are geographically co-located. A greater proportion of the Hutt Valley population receive services at CCDHB, than any other population as there are a large number of services that are provided by CCDHB

for the Hutt Valley population as well as services where there is collaboration across the two DHBs. There are very few services that are jointly provided. They include advanced care planning and the disability strategy. The most significant clinical service is MHAIDS.

The two DHBs have started to use the phrase 'hospital network'. A joint planning process will support the development of a hospital network that serves the Wellington, Kāpiti, Porirua and Hutt Valley communities. Identifying services that would benefit clinically, and financially, from joint provision across the network could significantly improve the ability of both DHBs to improve health outcomes with our available resources.

In the delivery of hospital and health services CCDHB is developing a work plan with its nationwide tertiary care partners and in the region as a complex care provider. This includes developing a clinical services planning approach in partnership with Hutt Valley DHB for services that may be shared.

In the delivery of Mental Health, Addiction and Intellectual Disability services CCDHB is a nationwide provider of complex services, a regional provider and the sub-regional provider.

CCDHB has strong relationships with its two PHOs and the NGO sector. The partners work together for system improvement through the local Alliance Leadership Team, the Integrated Care Collaborative (ICC).

Regional Public Health

Regional Public Health (RPH) is the public health unit for the sub-region (CCDHB, Hutt Valley DHB and Wairarapa DHB). Organisationally, RPH is part of Hutt Valley DHB. The three DHBs work in partnership with RPH in their work on health promotion/improvement, enhancing the effectiveness of prevention activities in other parts of the health system, and regulatory services.

The integration of Regional Public Health activity into locality and Community Health Network activity has commenced to ensure our efforts to improve health outcomes in our communities are aligned. The details about the activities of RPH are contained in the Regional Public Health 2019/20 Annual Plan.

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SECTION FIVE: Performance Measures

5.1 2019/20 Performance Measures

The DHB monitoring framework aims to provide a rounded view of performance using a range of performance markers. Four dimensions are identified reflecting DHB functions as owners, funders and providers of health and disability services. The four identified dimensions of DHB performance cover:

- achieving Government's priority goals/objectives and targets or 'Policy priorities'
- meeting service coverage requirements and supporting sector inter-connectedness or 'System Integration'
- providing quality services efficiently or 'Ownership'
- purchasing the right mix and level of services within acceptable financial performance or 'Outputs'.

Performance measure	Performance expectation	
MH01: Improving the health status of people with severe mental illness through improved access	Age 0-19	*To be reviewed following decisions that are made in regard to the MH&A Inquiry*
	Age 20-64	
	Age 65+	
MH02: Improving mental health services using wellness and transition (discharge) planning		95% of clients discharged will have a quality transition or wellness plan.
		≥95% of audited files meet accepted good practice.
MH03: Shorter waits for non-urgent mental health and addiction services for 0-19 year olds		*To be reviewed following decisions that are made in regard to the MH&A Inquiry*
CW01: Oral Health- Mean DMFT score at school Year 8	Year 1	≤0.49
	Year 2	TBC
CW02: Children caries-free at five years of age	Year 1	≥69%
	Year 2	TBC
CW03: Utilisation of DHB-funded dental services by adolescents School Year 9 up to and including age 17 years	Year 1	≥85%
	Year 2	≥85%
CW04: Improving the number of children enrolled in and accessing the Community Oral Health Service		
Number of Pre-School Children Enrolled in DHB-funded Oral Health Services	Year 1	≥95%
	Year 2	≥95%
Number of Enrolled Pre-School and Primary School Children Overdue for their Scheduled Examinations	Year 1	≤10%
	Year 2	≤10%
SS13: Improved management for long term conditions (CVD, Acute heart health, Diabetes, and Stroke)		
Focus Area 1: Long term conditions	Report on actions with an equity focus underway to support people with LTC to self-manage.	
	Report on actions with an equity focus underway to build health literacy.	
Focus Area 2: Diabetes services	Report on progress made in self-assessing diabetes services against the Quality Standards for Diabetes Care	
	Improve or, where high, maintain the proportion of patients with good or acceptable glycaemic control (HbA1C indicator).	
Focus Area 3: Cardiovascular health	Report on the percentage of the eligible population who have had a CVD risk assessment within the last five years AND the last ten years.	
	Report on the percentage of people assessed as high risk who have received an annual review.	

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	Report on the percentage of people assessed as high risk who have a blood pressure measurement of 130/80 mmHg or better.	
	Report on the percentage of people assessed as high risk with low density lipoproteins (LDL) less than 1.8mmol/L	
Focus Area 4: Acute heart service	≥70% of high-risk patients receive an angiogram within 3 days of admission.	
	≥95% of patients presenting with ACS who undergo coronary angiography who have completion of ANZACS QI ACS and Cath/PCI registry data collection within 30 days and ≥99% within 3 months.	
	≥85% of ACS patients who undergo coronary angiogram have pre-discharge assessment of LVEF	
	>85%: Composite Post ACS Secondary Prevention Medication Indicator - in the absence of a documented contraindication/intolerance all ACS patients who undergo coronary angiogram should be prescribed, at discharge, aspirin, a second anti-platelet agent, statin and an ACEI/ARB (4-classes), and those with LVEF<40% should also be on a beta-blocker (5-classes).	
Focus Area 5: Stroke services	≥10% or more of potentially eligible stroke patients are thrombolysed 24/7.	
	≥80% of stroke patients admitted to a stroke unit or organised stroke service with demonstrated stroke pathway.	
	≥80% of patients admitted with acute stroke who are transferred to inpatient rehabilitation services are transferred within 7 days of acute admission.	
	≥60% of patients referred for community rehabilitation are seen face to face by a member of the community rehabilitation team i.e. RN/PT/OT/SLT/SW/Dr/Psychologist within 7 calendar days of hospital discharge.	
CW05: Immunisation coverage	≥95% of two year olds fully immunised	
	≥95% of four year olds fully immunised	
	≥75% of girls fully immunised – HPV vaccine	
	≥75% of 65+ year olds immunised – flu vaccine	
PH01: Improving system integration and SLMs	Implementation of the SLM improvement plan by the district alliance is on track	
SS04: Implementing the Healthy Ageing Strategy	Report on actions and milestones to deliver on the commitment in the DHB's 2017/18 Annual Plan to implement the Healthy Ageing Strategy (including workforce regularisation)	
	Conversion rate of Contact Assessment (CA) to Home Care assessment where CA scores are 4–6 for assessment urgency	
CW12: Youth mental health initiatives	Initiative 1: Report on School Based Health Services (SBHS) in decile one to three secondary schools, teen parent units and alternative education facilities	
	Initiative 3: Youth Primary Mental Health. As reported through PP26 (see below).	
	Initiative 5: Improve the responsiveness of primary care to youth. Report on actions to ensure high performance of the youth service level alliance team (SLAT) (or equivalent) and actions of the SLAT to improve health of the DHB's youth population.	
MH04: Mental Health & Addiction Service Development	*To be reviewed following decisions that are made in regard to the MH&A Inquiry*	
CW11: Supporting child wellbeing	Report on child protection policies for funded providers; support provided to the regional Children's Team, for the ten DHBs that have Children's Teams in their region; and compliance reporting for the Vulnerable Children Act 2014.	
CW13: Reducing Rheumatic fever	Reducing the Incidence of First Episode Rheumatic Fever	≤1.0 per 100,000
PP29: Improving waiting times for diagnostic services	*Measure currently under review for CT, MRI and Angiography (excludes Colonoscopy) through the Planned Care refreshed Strategic approach work underway. Further information to be advised early in 2019. Colonoscopy likely to be included as a separate measure.*	
SS01: Faster cancer treatment	≥85% of patients receive their first cancer treatment (or other management) within 31 days from date of decision-to-treat.	
	Report on the activities being undertaken to ensure data quality and volumes; delays identified along the cancer pathway and challenges with implementing Faster cancer treatment; and, actions taken and planned in response to the delays and challenges identified.	
SS05: Better help for smokers to quit in public hospitals	≥95% of hospital patients who smoke and are seen by a health practitioner in a public hospital are offered brief advice and support to quit smoking.	
PH02: Improving the quality of ethnicity data collection in PHO and NHI registers	Report on progress with implementation and maintenance of Ethnicity Data Audit Toolkit (EDAT).	
PH03: Improving Māori enrolment in PHOs to meet the national average of 90%	*To be reviewed following decisions that are made in regard to the MH&A Inquiry*	
MH05: Reduce the rate of Māori under the Mental Health Act: section 29 community treatment orders	Reduce the rate of Māori under the Mental Health Act (s29) by at least 10% by the end of the reporting year.	

CW06: Improving breastfeeding rates		70% of infants are exclusively or fully breastfed at three months.
PP45: Elective Surgical Discharges		*Measure under review through Planned Care refreshed Strategic approach. Further information to be advised in February 2019.*
SS05: Ambulatory sensitive hospitalisations (adult)		TBC
SS2: Delivery of Regional Service Plans		Progress report on behalf of the region agreed by all DHBs within that region.
SS03: Ensuring delivery of Service Coverage		Report progress towards resolution of exceptions to service coverage identified in the Annual Plan, and not approved as long term exceptions, and any other gaps in service coverage (as identified by the DHB or by the Ministry).
SI4: Standardised Intervention Rates (SIRs)		*Measure under review through Planned Care refreshed Strategic approach. Further information to be advised in February 2019.*
SI5: Delivery of Whānau Ora		*Measure currently under review awaiting government decisions*
SS08: Improving Cervical Screening coverage		80% coverage for all ethnic groups and overall.
SS07: Improving breast screening coverage and rescreening		70% coverage for all ethnic groups and overall.
CW07: Improving newborn enrolment in General Practice		55% of newborns enrolled in General Practice by 6 weeks of age
		85% of newborns enrolled in General Practice by 3 months of age
OS3: Inpatient Average Length of Stay (ALOS)	Elective LOS	*Elective LOS Measure currently under review through the Planned Care refreshed Strategic approach work underway. Further information and updates to both Acute and Elective ALOS measures to be advised in early 2019.*
	Acute LOS	
OS8: Reducing Acute Readmissions to Hospital		*Measure under review through Planned Care refreshed Strategic approach. Further information to be advised in February 2019.*
SS09: Improving the quality of identity data within the National Health Index (NHI) and data submitted to National Collections *Some aspects of this measure remain under review to be updated in 2019.*		
Focus Area 1: Improving the quality of data within the NHI	New NHI registration in error (causing duplication)	>2% and <= 4%
	Recording of non-specific ethnicity in new NHI registrations	>0.5% and <= 2%
	Update of specific ethnicity value in existing NHI record with non-specific value	>0.5% and <= 2%
	Validated addresses excluding overseas, unknown and dot (.) in line 1	>76% and <= 85%
	Invalid NHI data updates	TBC
Focus Area 2: Improving the quality of data submitted to National Collections	NBRS links to NNPAC and NMDS	>= 97% and <99.5%
	National Collections File load Success	>= 98% and <99.5%
	Assessment of data reported to NMDS	>= 75%
	Timeliness of NNPAC data	>= 95% and <98%
Focus Area 3: Improving the quality of the Programme for the Integration of Mental Health data (PRIMHD)		Routine audits with appropriate corrective actions where required
MH06: Mental health output Delivery against Plan		Volume delivery for specialist Mental Health and Addiction services is within: a) five percent variance (+/-) of planned volumes for services measured by FTE, b) five percent variance (+/-) of a clinically safe occupancy rate of 85% for inpatient services measured by available bed day, and c) actual expenditure on the delivery of programmes or places is within 5% (+/-) of the year-to-date plan.
SS10: Shorter stays in Emergency Departments		95% of patients will be admitted, discharged, or transferred from ED within six hours.
SS11: Faster cancer treatment		90% of patients to receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks.
CW08 : Increased Immunisation		95% of eight-month-olds will have their primary course of immunisation (six weeks, three months and five month events) on time
PH04: Better help for smokers to quit (primary care)		90% of PHO enrolled patients who smoke have been offered help to quit smoking by a health care practitioner in the last 15 months
CW09: Better help for smokers to quit (maternity)		90% of pregnant women who identify as smokers upon registration with a DHB-employed midwife or Lead Maternity Carer are offered brief advice and support to quit smoking

CW10: Raising healthy kids	95% of obese children identified in the Before School Check (B4SC) programme will be offered a referral to a health professional for clinical assessment and family based nutrition, activity and lifestyle interventions.

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APPENDIX A: Statement of Intent

Foreword from Chair and Chief Executive

(Placeholder for 'Foreword from Chair and Chief Executive')

PART 1: Who we are and what we do

Introducing Capital & Coast DHB

Capital & Coast DHB is one of 20 DHBs established under the New Zealand Public Health and Disability Act (2000). We are the Government's funder and provider of health services to the residents living in the Kāpiti Coast District, Porirua City and Wellington City.

Who we are

The CCDHB region is a diverse community that incorporates the Kāpiti Coast District, Porirua City and Wellington City. In 2018, an estimated 318,000 people called the region home. This is projected to grow by 28,500 people by 2030; a 9% increase.

Infographic of growing population

In 2018, 106,400 people under 25 years of age made up 33% of the region's population, while 183,000 people aged 25-69 years represented 58% and, therefore, the bulk of the population. The remaining 9% of the population were people over 70 years; 29,000 people.

In 2018, Wellington had a large proportion of people in the younger working age group of 20–44 years (90,500 people), while nearly one-quarter (23%) of the Porirua population were aged under 15 years (13,000 people). Just over one-quarter (26%) of the Kāpiti Coast population were aged over 65 years; 11,500 people.

Infographic of population age distribution

The region is ethnically diverse. In 2018, 28,500 people identified as Māori (11% of the population), 21,000 identified as Pacific peoples (7%) and 35,500 identified as Asian (15%); 67 percent of the population identified in the 'Other' ethnic category (228,000).

Porirua had a larger proportion of Māori (16% or 9,000 people) and Pacific peoples (21% or 12,000 people), while 89 percent of the Kāpiti Coast population identified in the 'Other' ethnic category (70,800 people).

Our Māori and Pacific populations tend to be younger, with 29% of the region's Māori (10,600) and 27% of the region's Pacific people (6,000) aged under 15 years in 2018.

Infographic of diverse population

A changing population

The CCDHB population is changing: the population is growing, ageing and becoming more diverse. Overall, the population is predicted to grow by 9% by 2030.

The majority of the population increase is predicted to be in the Māori and Asian populations. Our Māori population is predicted to grow by 20% or 7,300 people. Our Asian population is predicted to grow by 43% or 20,300 people. Pacific peoples and 'Other' populations are expected to grow much more slowly and even decline in some younger age groups.

There will be significant growth in the number of older people in the region, as our large baby boomer generation shifts into older age brackets. The largest growth is expected be in the 70-79 and 80+ age groups; as our population is living to reach much older ages.

The health of our population

Compared to New Zealand as a whole, our population is relatively 'healthy and wealthy'. We have a high life expectancy at 82 years, rates of premature deaths from conditions amenable to healthcare have declined by

45% between 2000 and 2015, and the majority of our population (62%) live in areas of low deprivation.

However, we also have populations who experience inequitable health outcomes; in particular, Māori, Pacific peoples and those who live in highly deprived areas, concentrated in Porirua.

What we do

CCDHB is responsible for improving, promoting and protecting the health of the people, whānau and communities in our region. These expectations are reflected in our vision:

"Keeping our Community Healthy and Well."

Local Services

CCDHB provides community and hospital services throughout the region.

CCDHB operates two hospitals: Wellington Regional Hospital in Newtown and Kenepuru Community Hospital in Porirua. We also operate the Kāpiti Health Centre in Paraparaumu, and Te Korowai-Whāriki, a large mental health campus based in Porirua.

We provide a range of specialist services in the community including district nursing, rehabilitation services, social work, alcohol and drug services, and home support services.

CCDHB also has over *XXX* contracts with a range of community providers for services ranging such as *X and X*.

CCDHB provides *XX* sub-regional, regional and tertiary services for the other DHBs in the Central Region. CCDHB is also the national provider of genetics and artificial limbs services.

CCDHB employs around 5,700 staff and has an annual budget of $1.*XX* billion in 2019/20.

Sub-Regional Services

CCDHB provides services to the populations of Hutt Valley DHB and Wairarapa DHB under 2DHB (CCDHB and Hutt Valley DHB) and 3DHB models.

CCDHB and Hutt Valley DHB serve populations that are geographically co-located. CCDHB provides more services to the Hutt Valley DHB population than any other DHB. There are also DHB services provided to both populations, either at CCDHB or at Hutt Valley DHB.

In 2018, an estimated 150,000 people lived in Hutt Valley DHB. Hutt Valley's population has greater ethnic diversity and is slightly younger compared to CCDHB. Hutt Valley's population is predicted to grow by 4% or 6,500 people by 2030.

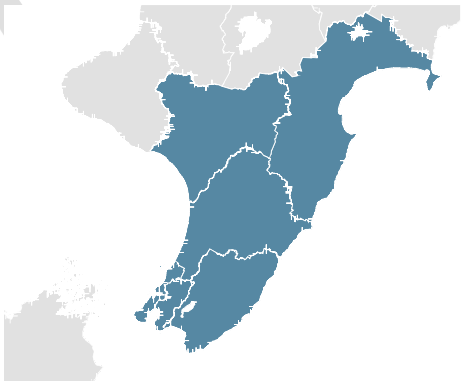
A further 45,500 people live in Wairarapa DHB. The population in the Wairarapa is projected to grow by 2,600 people (6%) by 2030.

Tertiary Services

CCDHB is the complex care provider for the Central region. This region includes Hawkes Bay, MidCentral, Whanganui, Wairarapa, Hutt Valley and Capital & Coast DHBs.

In 2018, the Central Region population was 922,855 people. This represents 19 percent of the total New Zealand population and is projected to grow by 6 percent by 2030 to just under one million people (978,900)[1].

Map of Central Region DHBs



Infographic 'A Year at CCDHB'

Achieving health equity in CCDHB

For CCDHB, equity is about looking at how well different population groups are doing compared with each other, identifying where the differences are and working to close the gap. We know that we don't do as well for Māori and Pacific Peoples in our district as we aim to, and we can see this in the health statistics. CCDHB is also committed to improving health outcomes and achieving equity for people with a mental illness and/or addiction or have a disability.

Improving equity performance is a priority for CCDHB. Our strategic priorities for addressing equity in 2019/20 include: the delivery of the Taurite Ora Action Plan and the CCDHB Equity Strategy 2019-2030, as well as further delivery of Toe Timata Le Upega, the Pacific Action Plan 2017-2020 and the Sub-Regional Disability Strategy 2017-2022. The CCDHB Equity Strategy puts in place the building blocks for CCDHB to advance as a pro-equity organisation.

CCDHB's strategic direction, to reduce and ultimately eliminate inequities, is driven by:

- Taurite Ora, CCDHB Māori Health Strategy 2018-2030
- CCDHB Equity Strategy 2019-2030,
- Toe Timata Le Upega, the Pacific Action Plan 2017-2020
- Sub-Regional Disability Strategy 2017-2022.

The key challenges we are facing

1. *Health inequities*

We have growing inequality in some communities which is fuelling health needs. As in most other countries, there are poorer health outcomes across the socioeconomic hierarchy.

Inequalities in health begin to appear very early in life, accumulate over the life course, and are reflected in most common causes of death, injury or hospitalisation.

2. *Child Wellbeing*

Text to be drafted

3. *Aging population*

The demand on our healthcare system continues to increase because the population is growing and ageing. Improvements in health will not necessarily reduce spending on healthcare.

The number of people aged over 70 years is expected to increase significantly. Forecasts suggest that by 2030 at least one in six people will be aged 70 years or over, and the population aged over 80 will increase by over 80 percent.

4. *Long-term conditions*

The impact of long-term conditions is growing. Although we are living longer, and living longer in good health, some people are living longer in poor health. The New Zealand Burden of Disease study found that 88 percent of health loss in this country is caused by long-term mental and physical conditions. We see this in the growing rate of obesity which has significant health and social impacts.

5. *Sustainability of Specialised Services*

Text to be drafted – LTIP, hospital network planning and tertiary service planning

6. *Financial sustainable*

The demand trends for health services, together with projected expenditure trends, mean that the cost of the current model of healthcare is unaffordable and unsustainable.

The Health System Plan (HSP) outlines the strategic direction that will allow Capital and Coast's health system to respond more effectively to the growing and changing needs of its people and populations, reduce inequalities and enable communities to better sustain their own health and well-being over time.

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Part 2: What are we trying to achieve?

Our Strategic Direction

The Capital & Coast DHB Health System Plan (HSP2030) is designed to support people and whānau-led wellbeing with the system organised around the two elements: 'People' and 'Place'.

People

The HSP2030 focuses on people in two ways:

1. By identifying the people that experience the greatest inequalities; to ensure they are a focus across the system and to ensure services are designed to reduce their inequalities
2. By major service user groups focusing on service design that supports people to be active partners in their own healthcare, with services delivered closest to their home.

Recognising those who need more help include: the socially & economic vulnerable; those with mental illness and addiction; those with disability; and Māori, Pacific and Refugees.

Infographic 'People'

Major Service User Groups include: those needing urgent or planned care; children, youth and families and whanau (including maternity care); and long term complex care users.

Place

The places where care is organised and delivered, together with increased access to better and cheaper technology, provide the platform for a comprehensive system of care.

The Plan centres on the following three core places/settings of care:

- people's homes and residential care facilities
- Community Health Networks (CHN) including the Healthcare Home
- Wellington and Kenepuru Hospital providing specialist care

Infographic 'Place'

We will achieve our obligations and deliver these outcomes as well as delivering services within available resources. We will also operate with a long-term view supported by the ten-year Long-Term Investment Plan. To do this we have a programme of work that builds on existing successes and finds new ways to:

These approaches will strengthen CCDHB's ability to be people powered, provide services closer to home, operate as one team, use smart systems and ensure value and high performance.

Improving the health and wellbeing of communities requires a more broad approach than the traditional boundaries of health and social services. Partnership with communities (including Councils, Government Agencies, NGOs from other sectors and community organisations) to strengthen their contribution to their own health and wellbeing is required to better respond to the social determinants of health.

CCDHB is well placed to successfully deliver against the New Zealand Health Strategy objectives, as we implement our longer term view of how services will be delivered for our population (HSP2030).

Focus for 2019/20

CCDHBs focus is on delivering on the HSP2030. The HSP outlines our strategy, or roadmap, to improve the performance of the region's healthcare system.

Key programmes and initiatives in 2019/20

Key projects for 2019/20 to be outlined here: pending approval of draft Annual Plan by the Board

Health and safety

At CCDHB the health and safety of all workers, patients and all others utilising our facilities and services is paramount.

CDHB is committed to the development and maintenance of a positive health and safety culture, providing safe and secure facilities, having well trained, instructed and supervised workers, to ensure their and others safety.

Workforce

CCDHB strives to be a good employer and is aware of our legal and ethical obligations. We are aware that good employment practices are critical to attracting and retaining top health professionals and support staff who embody our values and culture in their practice and contribution to organisational life.

We recognise the aims, aspirations, cultural differences and employment requirements of Māori people, Pacific Peoples and people from other ethnic or minority groups. We will prioritise a range of strategies with a particular focus on the recruitment and retention of Māori and Pacific staff. We will provide opportunities

for individual employee development and career advancement, including cultural competency training.

CCDHB's People Strategy has the following principles and strategic intent:

Principle	Strategic Intent
Strong foundations	Invest in the fundamental building blocks that ensure our people have the skills and tools to excel and to lift health outcomes for our whole population, with a focus on Māori and Pacific Peoples.
Trust and partnership	Support open respectful communication, shared decision making, easy processes, transparency and individual accountability.
Promoting wellbeing	Work together for the health and wellbeing of our people and the community we serve.
Learning from excellence	Foster innovation to ensure we do more of what we do well. Recognise the efforts and contribution of individuals, teams, leaders and managers.

Sub-Regional, Regional and National Strategic Direction

Sub-Regional Strategic Direction – Hospital Network Planning

CCDHB and Hutt Valley DHB share a Chief Executive and a Board Chair. Our Boards hold joint bi-monthly meetings which allows further collaboration and a more integrated and aligned approach to planning and delivery of health services across the two DHBs.

Some of the services that are delivered across the two DHBs include: *x, y and z.*

Mental Health and Addiction Services are delivered across three DHBs: Wairarapa DHB, Hutt Valley DHB and Capital and Coast DHB.

Regional Strategic Direction – Tertiary Services Strategy and Regional Clinical Services Planning

Tertiary Services Strategy *– CCDHB's Tertiary Services Strategy for regional/tertiary services; wording to be included here*

Regional Clinical Services *- Planning Priorities to be included here*

An implementation programme has been developed focussed on the key regional strategic priorities:

- Equity
- Tertiary Strategy
- Radiology
- Cardiology
- Cancer

National Strategic Direction

The Minister's Letter of Expectations outlines the Government's priorities for health to ensure that our public health system is: strong and equitable, performing well, and focused on the right things to make all New Zealanders' lives better. The priorities for 2019/20 include:

- Achieving Equity
- Strong and Equitable Public Health and Disability System
- Mental Health and Addiction Care
- Child Wellbeing
- Primary Health Care
- Non-Communicable Disease (NCD) Prevention and Management
- Public Health and the Environment
- Fiscal Responsibility

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PART 3: Annual operating intentions – What can you expect from us?

Measuring performance - Integrated Performance Framework

Regional high-level outcomes

The Triple Aim framework aims to optimise health system performance: Improved quality, safety, and experience of care at individual level; improved health and equity for all populations at population level; and best value for public health system resources at system level.

Our Purpose

The strategic focus areas, as outlined in the HSP, are to:

Promote health and wellbeing
Prevent the onset and development of avoidable illness
Strengthen the health and wellbeing of people
Support people to live better lives
Support the end of life with dignity

DHB long term outcomes

CCDHBs long term population outcome goals, as outlined in the HSP, are:

Strengthening our communities and families so they can be well
It is easier for people to manage their own health needs
We have equal health outcomes for all communities
Long term health conditions and complexity occur later in life and shorter duration
Expert specialist services are available to improve health gain

System Level Measures (SLMs)

The national System Level Measures (SLMs) Framework has been developed with a system-wide view of performance.

The six SLMs implemented and reported against are:

1. Proportion of babies who live in smoke-free household at six weeks post-natal;
2. Ambulatory sensitive hospitalisation rates for 0-4 year olds;
3. Youth access to and utilisation of youth-appropriate health services;
4. Acute bed days;
5. Amenable mortality rates under 75 years; and
6. Patient experience of care.

Service level measures

The service level measures, as outline in the statement of performance expectations, are reported against the following output classes: prevention, early detection and management, intensive assessment and treatment, and rehabilitation and support.

Local inputs/enablers

Workforce, regional networks and relationships, quality systems and processes, health information and systems, patient and community experience, assets and infrastructure

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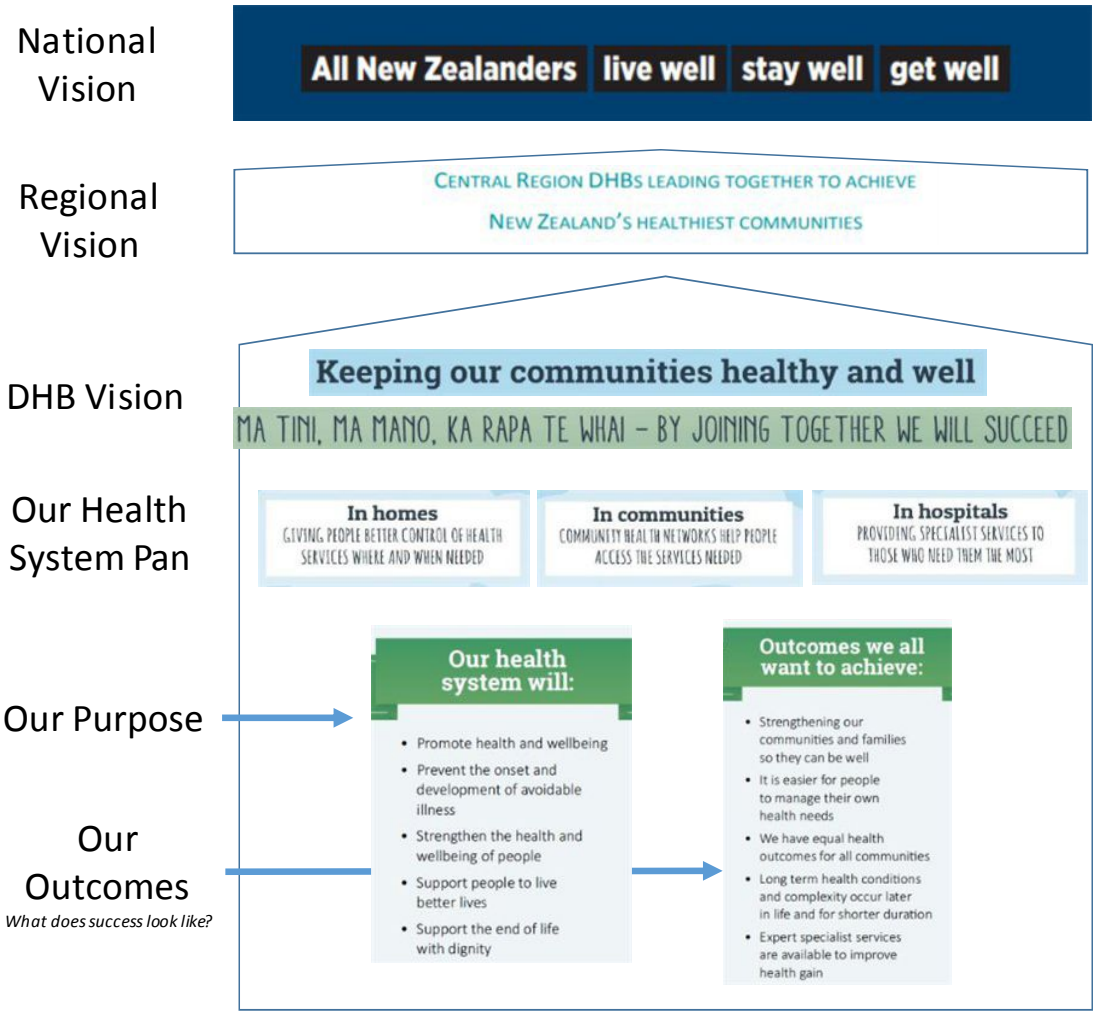
Integrated Performance Framework Infographic *under development*



APPENDIX B: Statement of Performance Expectations including Financial Performance

This section must be tabled in Parliament. All components of this section are mandatory (section 149C of the Crown Entities Act 2004[5])

As both the major funder and provider of health services in the Capital & Coast DHB region, the decisions we make and the way in which we deliver services have a significant impact on the health and wellbeing our population and communities.

Having a limited resource pool and growing demand for health services, we are strongly motivated to ensure we are delivering the most effective and efficient services possible.

On an annual basis, we evaluate our performance by providing a forecast of the services we plan to deliver and the standards we expect to meet. The results are then presented in our Annual Report at year end.

The following section presents Capital & Coast DHB's Statement of Performance Expectations for 2019/20.

Interpreting Our Performance

As it would be overwhelming to measure every service delivered, the services we deliver have been grouped into four services classes. These are common to all DHBs and reflect the types of services provided across the full health and wellbeing continuum:

- Prevention services
- Early detection and management services
- Intensive assessment and treatment services
- Rehabilitation and support services

Under each service class, we have identified a mix of service measures that we believe are important to our community and stakeholders, and provide a fair indication of how well the DHB is performing.

Setting Standards

In setting performance standards, we consider the changing demography of our population, areas of increasing demand and the assumption that resources and funding growth will be limited.

Our performance standards reflect the outcomes the DHB is wanting to achieve:

- Strengthen our communities and families so they can be well;
- It is easier for people to manage their own health needs;
- We have equal health outcomes for all communities;
- Long term health conditions and complexity occur later in life and for shorter duration; and,
- Expert specialist services are available to improve health gain.

We also seek to improve the experience of people in our care and public confidence in our health system.

While targeted intervention can reduce service demand in some areas, there will always be some demand the DHB cannot influence, such as demand for maternity services and palliative care services. It is not appropriate to set targets for these services, however they are an important part of the picture of health need and service delivery in our region.

In health, the number of people who receive a service can be less important than whether enough of the right people received the service, or whether the service was delivered at the right time. To ensure a balanced, well rounded picture, the mix of measures identified in our Statement of Performance Expectations address four key aspects of service performance:

Access	How well are people accessing services, is access equitable, are we engaging with all of our population?
Timeliness	How long are people waiting to be seen or treated, are we meeting expectations?
Quality	How effective is the service, are we delivering the desired health outcomes?
Experience	How satisfied are people with the service they receive, do they have confidence in us?

With a growing diversity and persistent inequities across our population, achieving equity of outcomes is an overarching priority for the DHB. All of our targets are universal, with the aim of reducing disparities between population groups.

Where does the money go?

In 2019/20, the DHB will receive approximately $*XXX* billion dollars with which to purchase and provide the services required to meet the needs of our population.

The table below represents a summary of our anticipated financial split for 2019/20 by service class.

	2019/20
Revenue	**Total $'000**
Prevention	
Early detection & management	
Intensive assessment & treatment	
Rehabilitation & support	
Total Revenue - $'000	
Expenditure	
Prevention	
Early detection & management	
Intensive assessment & treatment	
Rehabilitation & support	
Total Expenditure - $'000	
Surplus/(Deficit) - $'000	

[5] Henceforth, 'CE Act' will be used when referring to the Crown Entities Act 2004.

Prevention Services

Why are these services significant?

Prevention services are publically funded services that promote and protect the health of the whole population or targeted populations. These services seek to address individual behaviours by targeting physical and social environments and norms that can influence and support people to make healthier choices and are, in this way, distinct from treatment services.

The four leading long-term conditions; cancer, cardiovascular disease, diabetes, and respiratory disease—make up 80% of the disease burden for our population. By supporting people to make healthier choices we can reduce the risk factors that contribute to these conditions. High-need population groups are also more likely to engage in risky behaviours, or live in environments less conducive to making healthier choices. Prevention services are therefore one of our foremost opportunities to target improvements in the health of high-need populations and reduce inequities in health status and health outcomes. Prevention services are designed to spread consistent messages to a large number of people and can therefore be a very cost-effective health intervention.

How will we demonstrate our success?

Immunisation Services				
These services reduce the transmission and impact of vaccine-preventable diseases, both routinely and in response to specific risk. Engagement in programmes and high coverage rates are indicative of a well-coordinated, successful service	Target Group	Baseline 2017/18	Forecast 2018/19	Target 2019/20
% of eight month olds fully vaccinated	Māori	96%	86%	≥95%
	Pacific	90%	94%	
	Other	95%	96%	
	Total	93%	94%	
% of two year olds fully immunised	Māori	93%	90%	≥95%
	Pacific	98%	94%	
	Other	96%	94%	
	Total	96%	94%	
% of five year olds fully immunised	Māori	88%	84%	≥95%
	Pacific	96%	91%	
	Other	92%	91%	
	Total	92%	89%	
% of Year 7 children provided Boostrix vaccination in schools	Māori	80%	80%	≥70%
	Pacific	82%	82%	
	Other	*TBC*	*TBC*	
	Total	68%	68%	
% of Year 8 girls vaccinated against HPV in schools	Māori	64%	64%	≥75%
	Pacific	75%	75%	
	Other	*TBC*	*TBC*	
	Total	64%	64%	

Health Promotion Services				
These services inform people about risk, and support them to make healthy choices. Success is evident through increased engagement, which leads over time to more positive behaviour choices and a healthier population.	Target Group	Baseline 2017/18	Forecast 2018/19	Target 2019/20
% of infants fully or exclusively breastfed at 3 months	Māori	52%	50%	≥60%
	Pacific	44%	54%	
	Other	68%	69%	
	Total	63%	65%	
% of four year olds identified as obese at their B4 School Check referred for family based nutrition, activity and lifestyle intervention	Māori	96%	97%	≥95%
	Pacific	97%	97%	
	Other	91%	100%	
	Total	95%	95%	
% of PHO-enrolled patients who have quit smoking in the last 12 months	Māori	9%	8%	*TBC*
	Pacific	9%	8%	
	Other	15%	14%	
	Total	13%	12%	

Population-based Screening Services				
These services help to identify people at risk of developing a long-term condition and support earlier intervention and treatment. Success is reflected by engagement in programmes and high coverage rates across the population.	Target Group	Baseline 2017/18	Forecast 2018/19	Target 2019/20
% of eligible children receiving a B4 School Check	Māori	82%	84%	≥90%
	Pacific	81%	90%	
	Other	94%	92%	
	Total	90%	90%	
	Māori	*TBC*	*TBC*	≥95%

% of youth who have a HEEADSS assessment in DHB funded school based health services	Pacific	*TBC*	*TBC*	
	Other	*TBC*	*TBC*	
	Total	*TBC*	*TBC*	
% of eligible women (25-69 years old) having cervical screening in the last 3 years	Māori	61%	63%	≥80%
	Pacific	68%	66%	
	Other	79%	79%	
	Total	77%	77%	
% of eligible women (50-69 years old) having breast cancer screening in the last 2 years	Māori	67%	68%	≥70%
	Pacific	70%	69%	
	Other	73%	72%	
	Total	73%	72%	

Public Health Services				
These services address aspects of the physical, social and built environment in order to protect health and improve health outcomes.	Target Group	Baseline 2017/18	Forecast 2018/19	Target 2019/20
Number of disease notifications investigated	Māori	109	109	*TBC*
	Pacific	92	92	*TBC*
	Other	*TBC*	*TBC*	*TBC*
	Total	1,291	1,291	*TBC*
Number of new referrals to Public Health Nurses in primary/intermediate schools	Māori	756	756	*TBC*
	Pacific	707	707	*TBC*
	Other	*TBC*	*TBC*	*TBC*
	Total	1,887	1,887	*TBC*
Number of submissions providing strategic public health input and expert advice to inform policy and public health programming in the sub-region	Total	*TBC*	*TBC*	*TBC*
Number of environmental health investigations	Total	727	727	*TBC*
Number of premises visited for alcohol controlled purchase operations	Total	70	70	*TBC*
Number of premises visited for tobacco controlled purchase operations	Total	17	17	*TBC*
Number of assessments related to requirements of the Drinking-Water Standards	Total	*TBC*	*TBC*	*TBC*

Early Detection and Management Services

Why are these services significant?

The New Zealand health system is experiencing an increasing prevalence of long-term conditions; so-called because once diagnosed, people usually have them for the rest of their lives. Some population groups suffer from these conditions more than others and prevalence increases with age.

Our Health System Plan is designed to support people and whānau-le wellbeing with the system organised around two elements: People and Place. For most people, their general practice team is their first point of contact with health services and is vital as a point of continuity in improving the management of care for people with long-term conditions. By promoting regular engagement with primary and community services we are better able to support people to stay well, identify issues earlier, and reduce complications, acute illness and unnecessary hospital admissions. Our approach will be particularly effective where people have multiple conditions requiring ongoing intervention or support.

How will we demonstrate our success?

Oral Health Services				
These services help people maintain healthy teeth and gums and support lifelong health and wellbeing. High levels of enrolment and timely access to treatment are indicative of an accessible and efficient service.	Target Group	Baseline 2017/18	Forecast 2018/19	Target 2019/20
% of children under 5 years enrolled in DHB-funded dental services	Māori	67%	*TBC*	≥95%
	Pacific	80%	*TBC*	
	Other	103%	*TBC*	
	Total	94%	*TBC*	
% of children caries free at 5 years	Māori	51%	*TBC*	≥69%
	Pacific	39%	*TBC*	
	Other	77%	*TBC*	
	Total	70%	*TBC*	
Ratio of mean decayed, missing, filled teeth (DMFT) at year 8	Māori	0.79	*TBC*	≤0.49
	Pacific	0.97	*TBC*	
	Other	0.41	*TBC*	
	Total	0.51	*TBC*	
% of children (0-12) enrolled in DHB oral health services examined according to planned recall	Māori	14%	*TBC*	≤10%
	Pacific	14%	*TBC*	
	Other	12%	*TBC*	
	Total	12%	*TBC*	
% of adolescents accessing DHB-funded dental services	Māori	*TBC*	*TBC*	≥85%
	Pacific	*TBC*	*TBC*	
	Other	*TBC*	*TBC*	
	Total	80%	*TBC*	

Primary Care Services				
These services support people to maintain and manage their health and wellbeing and avoid unnecessary hospital admissions. High levels of enrolment and engagement with general practice are indicative of an accessible and responsive service.	Target Group	Baseline 2017/18	Forecast 2018/19	Target 2019/20
% of the DHB-domiciled population that is enrolled in a PHO	Māori	86%	85%	≥94%
	Pacific	*TBC*	*TBC*	
	Other	*TBC*	*TBC*	
	Total	*TBC*	*TBC*	
% of the eligible population assessed for CVD risk in the last five (ten) years	Māori	83%	82%	≥90%
	Pacific	85%	83%	
	Other	83%	82%	
	Total	83%	82%	
% of people with diabetes aged 15-74 years enrolled with a PHO who latest HbA1c in the last 12 months was <=64 mmol/mol	Māori	61%	61%	≥70%
	Pacific	51%	56%	
	Other	70%	69%	
	Total	66%	66%	
Avoidable hospital admission rate for children aged 0-4 (per 100,000 people)	Māori	7,330	8,143	*TBC*
	Pacific	10,100	10,297	
	Other	5,039	5,700	
	Total	6,038	6,685	
Avoidable hospital admission rate for adults aged 45-64 (per 100,000 people)	Māori	6,163	6,070	*TBC*
	Pacific	6,636	7,893	
	Other	2,387	2,537	
	Total	2,943	3,140	
Primary Care Patient Experience scores	Communication	8.5	8.4	*TBC*
	Partnership	7.6	7.5	
	Physical & Emotional Needs	7.8	7.8	

	Coordination	8.4	8.5	

Pharmacy Services				
These are services which a health professional uses to help diagnose or monitor a health condition. While largely demand driven, timely access to services enables improved clinical decision-making and reduces unnecessary delays in treatment, and is therefore indicative of a successful service.	Target Group	Baseline 2017/18	Forecast 2018/19	Target 2019/20
% of the DHB-domiciled population that were dispensed at least one prescription item	Māori	*TBC*	*TBC*	*TBC*
	Pacific	*TBC*	*TBC*	
	Other	*TBC*	*TBC*	
	Total	78%	*TBC*	
Number of people registered with a Long Term Conditions programme in a pharmacy	Māori	*TBC*	*TBC*	*TBC*
	Pacific	*TBC*	*TBC*	
	Other	*TBC*	*TBC*	
	Total	6,823	*TBC*	
Number of people participating in a Community Pharmacy Anticoagulant Management service in a pharmacy	Māori	*TBC*	*TBC*	*TBC*
	Pacific	*TBC*	*TBC*	
	Other	*TBC*	*TBC*	
	Total	225	*TBC*	
% of people receiving five or more long-term medications	Māori	*TBC*	*TBC*	*TBC*
	Pacific	*TBC*	*TBC*	
	Other	*TBC*	*TBC*	
	Total	*TBC*	*TBC*	

Intensive Assessment and Treatment Services

Why are these services significant?

Intensive assessment and treatment services are more complex services provided by specialists and health professionals working closely together. They are usually provided in hospital settings, which enables the co-location of expertise and equipment. A proportion of these services are delivered in response to acute events; others are planned, and access is determined by clinical triage, capacity, treatment thresholds and national service coverage agreements.

Timely access to intensive assessment and treatment can significantly improve people's quality of life through corrective action and is crucial to improving survival rates for complex illness such as cancer. Responsive services and timely access to treatment also enable people to establish more stable lives, and result in improved confidence in the health system.

As a provider of specialist services, the DHB is committed to ensuring the quality of its service provision. Adverse events and delays in treatment, as well as causing harm to patients, drive unnecessary costs. Improved processes will support patient safety, reduce the number of events causing injury or harm, and improve health outcomes for our population.

How will we demonstrate our success?

Maternity Services				
These services are provided to women and their families through pre-conception, pregnancy, childbirth and the early months of a baby's life. Demand driven, service utilisation is monitored to ensure services are accessible and responsive to need.	Target Group	Baseline 2017/18	Forecast 2018/19	Target 2019/20
% of maternity deliveries made in Primary Birthing Units	Māori	21%	*TBC*	≥9%
	Pacific	22%	*TBC*	
	Other	8%	*TBC*	
	Total	11%	11%	

Acute and Urgent Services				
These are services delivered in response to accidents or illnesses that have an abrupt onset or progress rapidly. While largely demand driven, not all acute events require hospital treatment. Because early intervention can reduce the impact of the event, multiple options and shorter waiting times are indicative of a responsive system.	Target Group	Baseline 2017/18	Forecast 2018/19	Target 2019/20
Number of acute demand packages of care provided in community settings	Total	*TBC*	*TBC*	*TBC*
Number of extended hours	Total	*TBC*	*TBC*	*TBC*
Age-standardised ED presentation rate per 1,000 population	Māori	196	198	*TBC*
	Pacific	250	243	
	Other	158	152	
	Total	166	161	
% of patients admitted, discharged or transferred from ED within 6 hours	Māori	89%	86%	≥95%
	Pacific	90%	85%	
	Other	90%	87%	
	Total	90%	87%	
Standardised inpatient average length of stay (ALOS) in days	Total	2.24	2.25	*TBC*

Elective & Arranged Services				
These are medical and surgical services provided for people who do not need immediate hospital treatment, where their assessment or treatment is booked or arranged. Maintaining access while reducing waiting times is indicative of an efficient service.	Target Group	Baseline 2017/18	Forecast 2018/19	Target 2019/20
Number of surgical elective discharges	Māori	11,341	*TBC*	*TBC*
	Pacific		*TBC*	
	Other		*TBC*	
	Total		*TBC*	
Standardised inpatient average length of stay (ALOS) in days, Elective	Total	1.55	1.56	*TBC*
% of patients given a commitment to treatment but not treated within four months	Total	*TBC*	*TBC*	0%
% of "DNA" (did not attend) appointments for outpatient appointments	Māori	15%	*TBC*	*TBC*
	Pacific	17%	*TBC*	
	Other	*TBC*	*TBC*	
	Total	8%	*TBC*	
% of patients waiting longer than four months for their first specialist assessment	Total	*TBC*	*TBC*	0%
% of patients with a high suspicion of cancer and a need to be seen within two weeks that received their first cancer treatment (or other management) within 62 days of being referred	Māori	*TBC*	*TBC*	≥90%
	Pacific	*TBC*	*TBC*	
	Other	*TBC*	*TBC*	
	Total	90%	88%	

Mental health, addictions and wellbeing services

These are services for those most severely affected by mental illness and/or addictions who require specialist intervention and treatment. Reducing waiting times, while meeting an increasing demand for services, is indicative of a responsive and efficient service.		Target Group	Baseline 2017/18	Forecast 2018/19	Target 2019/20
% of population accessing community mental health services		Māori	*TBC*	*TBC*	*TBC*
		Pacific	*TBC*	*TBC*	
		Other	*TBC*	*TBC*	
		Total	*TBC*	*TBC*	
% of population accessing secondary mental health services		Māori	*TBC*	*TBC*	*TBC*
		Pacific	*TBC*	*TBC*	
		Other	*TBC*	*TBC*	
		Total	*TBC*	*TBC*	
% of patients 0-19 referred to non-urgent child & adolescent services that were seen within eight weeks:	Mental health services	Māori	*TBC*	*TBC*	≥95%
		Pacific	*TBC*	*TBC*	
		Other	*TBC*	*TBC*	
		Total	89%	92%	
	Addiction services	Māori	*TBC*	*TBC*	
		Pacific	*TBC*	*TBC*	
		Other	*TBC*	*TBC*	
		Total	92%	98%	
% of people admitted to an acute mental health inpatient service that were seen by mental health community team:	7 days prior to the day of admission	Māori	*TBC*	*TBC*	≥75%
		Pacific	*TBC*	*TBC*	
		Other	*TBC*	*TBC*	
		Total	62%	*TBC*	
	7 days following the day of discharge	Māori	*TBC*	*TBC*	≥90%
		Pacific	*TBC*	*TBC*	
		Other	*TBC*	*TBC*	
		Total	73%	*TBC*	
Rate of Māori under the Mental Health Act: Section 29 community treatment orders		Māori	520	482	*TBC*
		Non- Māori	139	139	*TBC*

Quality, safety and patient experience					
These quality and patient safety measures are national markers championed and monitored by the NZ Health Quality & Safety Commission. High compliance levels indicate quality processes and strong clinical engagement.		Target Group	Baseline 2017/18	Forecast 2018/19	Target 2019/20
Rate of identified opioid medication errors causing harm, per 1,000 bed days		Māori	*TBC*	*TBC*	≤5
		Pacific	*TBC*	*TBC*	
		Other	*TBC*	*TBC*	
		Total	*TBC*	*TBC*	
Rate of Hospital Acquired Pressure Injuries, per 1,000 bed days		Māori	*TBC*	*TBC*	≤0.3
		Pacific	*TBC*	*TBC*	
		Other	*TBC*	*TBC*	
		Total	0.2	*TBC*	
Rate of inpatient falls causing harm per 1,000 bed days		Māori	*TBC*	*TBC*	≤0.2
		Pacific	*TBC*	*TBC*	
		Other	*TBC*	*TBC*	
		Total	0.5	*TBC*	
Number of in-hospital cardiopulmonary arrests in adult inpatient wards		Māori	*TBC*	*TBC*	35
		Pacific	*TBC*	*TBC*	
		Other	*TBC*	*TBC*	
		Total	*TBC*	*TBC*	
The weighted average score in the Inpatient Experience Survey by domain		Communication	8.5	8.5	8.4 - 8.6
		Partnership	8.7	8.5	
		Physical & Emotional Needs	8.7	8.6	
		Coordination	8.4	8.1	

Rehabilitation and Support Services

Why are these services significant?

Rehabilitation and support services provide people with the assistance they need to live safely and independently in their own homes or regain functional ability after a health related event. These services are considered to provide people with a much higher quality of life as a result of people being able to stay active and positively connected to their communities. This is evidenced by less dependence on hospital and residential services and a reduction in acute illness, crisis or deterioration leading to acute admission or readmission into our hospitals.

Even when returning to full health is not possible, timely access to responsive support services enables people to maximise their independence. In preventing deterioration, acute illness or crisis, these services have a major impact on the sustainability of our health system by reducing acute demand, unnecessary ED presentations and the need for more complex interventions. These services also support patient flow by enabling people to go home from hospital earlier.

Support services also include palliative care for people who have end-of-life conditions. It is important that they and their families are appropriately supported, so that the person is able to live comfortably and have their needs met in a holistic and respectful way, without undue pain and suffering.

How will we demonstrate our success?

Disability Support Services				
These services support people with disabilities to find solutions to support their engagement in health services. Success is measured by responsive services that support people with disabilities and consumer-clinician partnership.	Target Group	Baseline 2017/18	Forecast 2018/19	Target 2019/20
Number of CCDHB Disability Forums	Total	0	*TBC*	1
Number of sub-regional Disability Forums	Total	0	*TBC*	1
% of hospital staff that have completed the Disability Responsiveness eLearning Module	Total	18%	*TBC*	*TBC*
Number of people with a Disability Alert	Total	8,357	*TBC*	*TBC*
% of the Disability Alert Population who are Māori or Pacific	Māori	*TBC*	*TBC*	*TBC*
	Pacific	*TBC*	*TBC*	*TBC*
	Other	*TBC*	*TBC*	*TBC*
	Total	*TBC*	*TBC*	*TBC*

Home-based and Community Support Services				
These services aim to restore or maximise people's health or functional ability, following a health-related event such as a fall, heart attack or stroke. Largely demand-driven, success is measured through appropriate service referral following an event.	Target Group	Baseline 2017/18	Forecast 2018/19	Target 2019/20
% of people 65+ receiving DHB-funded HOP support who are being supported to live at home	Māori	*TBC*	*TBC*	≥63%
	Pacific	*TBC*	*TBC*	
	Other	*TBC*	*TBC*	
	Total	62%	*TBC*	
% of people 65+ who have received long term home support services in the last three months who have had a comprehensive clinical (interRAI) assessment and a completed care plan	Māori	100%	100%	≥98%
	Pacific	100%	100%	
	Other	100%	100%	
	Total	100%	100%	
% of people who have had an interRAI assessment with an Advance Care Plan	Total	4.1%	4.2%	*TBC*
Rate of hip (neck of femur) fractures due to a fall per 1,000 people 50+	Māori	*TBC*	0.6	*TBC*
	Pacific	*TBC*	--	*TBC*
	Other	*TBC*	1.8	*TBC*
	Total	2.6	2.5	*TBC*
Number of older people accessing respite services	Total	*TBC*	*TBC*	*TBC*

Aged Residential Care Services				
With an ageing population, demand for aged related care (ARC) is expected to increase, but a reduction in demand for lower-level residential care is indicative of more people being successfully supported for longer in their own homes. The DHB subsidises ARC for people who meet the national thresholds for care.	Target Group	Baseline 2017/18	Forecast 2018/19	Target 2019/20
Rate of ED presentations from aged residential care facilities that are not admitted per 1,000 population in aged residential care	Māori	*TBC*	*TBC*	*TBC*
	Pacific			
	Other			
	Total			
% of residential care providers meeting four year certification standards	Total	53%	*TBC*	*TBC*

Financial Performance

(Placeholder for Financial Performance Tables – pending release of the Funding Envelope)

APPENDIX C: System Level Measures Improvement Plan

(Placeholder for System Level Measures Improvement Plan)

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Capital & Coast District Health Board ŪPOKO KI TE URU HAUORA	**HEALTH SYSTEM COMMITTEE DECISION**
	Date: 6 March 2019

Author	Chad Parone, Finora Management Services Rachel Haggerty, Director, Strategy Innovation & Performance
Endorsed by	Arawhetu Gray, Director, Maori Health Services Taima Fagaloa, Director, Pacific People's Health
Subject	**BECOMING A PRO-EQUITY ORGANISATION**

RECOMMENDATIONS

It is **recommended** that the Health System Committee:

(a) **Notes** the Pro-Equity Check-Up Report completed by BakerJones and its findings;

(b) **Notes** the attached research on Government Health Advisory Groups;

(c) **Approves** the development of a work programme that delivers

I. A clear CCDHB equity goal and direction

II. An agreed set of equity principles

III. An operational framework that translates principles into practice in areas including workforce, service commissioning, service performance and health outcomes

IV. A performance framework to monitor and guide progress.

(d) **Notes** that the Work Programme will be presented to the Committee in June 2019.

APPENDICES

1. Pro-Equity Check Up Report December 2018;
2. Māori and Pasifika Leaders Experience of Government Health Advisory Groups in New Zealand.

Health System Plan Outcomes		**Stewardship**	
Wellbeing Strengthen our communities, families and whānau so they can be well		**Quality & Safety** Quality & safety of service delivery	
People Centred Make it easier for people to manage their own health needs		**Service Performance** Report on service performance.	
Equity Support equal health outcomes for all communities	**X**	**Health System Performance** Report on health system performance	
Prevention Delay the onset, and reduce the duration and complexity, of long-term health conditions		**Planning Processes and Compliance** Planning processes and compliance with legislation or policy.	
Specialist Services Ensure expert specialist services are available to help improve people's health		**Government Priority** Equity; Child Wellbeing; Mental Health; Primary Care; Water Safety	**X**

1 PURPOSE

Equity is a priority of this Government. Achieving equity in healthcare and health status is a challenge for health systems worldwide, including New Zealand. To assist Capital & Coast District Health Board (CCDHB)

to achieve equity we commissioned a pro-equity assessment to assist in understanding our current status including how well CCDHB is embedding a pro-equity approach into its work.

The report (attached) sets out several findings and recommendations. This memo summarises the key points made in the report and suggests how we might progress this, together, across CCDHB.

2 INTRODUCTION

Like other DHBs, CCDHB has been grappling with health inequity across the populations we serve. Māori, Pasifika and low-income families generally feature more prominently in this picture of inequity, encountering greater challenges around access to timely, quality healthcare, which contributes to poorer health status.

Despite the best intentions and efforts of CCDHB individuals and teams over the years, and small advances made in various quarters, this inequity has proved stubbornly persistent. There is little to indicate that without a systematic approach it will change. Attached as Appendix 2 is published research which highlights the significant challenges for Māori and Pasifika leaders in guiding health systems to improve equity.

"Our findings show that inequalities in the health system are reproduced in advisory committees. Participants noted their knowledge and interests were devalued and they experienced racism and tokenistic engagement. Some indicated it took considerable effort to establish credibility, be heard, have impact, and navigate advisory meetings, but even then their inputs were marginalised. Health policy advisory committees need deeper engagement and more genuine recognition of Māori and Pasifika knowledge. Māori and Pasifika leaders have constructive solutions for eliminating health inequities that could benefit all New Zealanders".

If CCDHB is to bring about a change in this pattern of inequity, it requires a change in the way we approach equity. There is nothing to suggest that continuing to do the same things in the same way will lead to a different result. We must be prepared to adjust the way we think, plan and operate. The bigger the change we seek to make, the greater the shift we must make as CCDHB.

3 STATUS CHECK

The commissioning of a pro-equity check-up for CCDHB was the first step in understanding where the organisation currently stands in terms of delivering on health equity for our populations.

From October to December 2018, an independent review was conducted that included a document review, 16 interviews with DHB and other senior players, three online surveys of DHB staff (Executive Leadership Team (ELT) members, tier 3 staff, and all staff) that garnered 150 responses, and a workshop with 40+ staff from the Strategy, Innovation and Performance team (SIP). The resulting report was delivered in December.

In short, the results highlighted that, while there is stated high-level commitment to the goal of achieving equity, and a general awareness of the key issues, this has not translated into a consistent and comprehensive response across the whole of the DHB. We are not doing enough to embed a pro-equity approach into the way CCDHB thinks and operates.

The following table summarises the key findings of the CCDHB Pro-Equity Checkup.

Commitment and Accountability	1) Good intentions not translating to action
	2) No coherent approach to equity across the organisation
	3) No clear accountabilities for equity at each level of the organisation
Strengthening participation	4) A focus on getting the right voice around the table, but this is not enough
	5) More needed to build the Maori and Pacific health workforce
	6) Significant opportunities to improve CCDHB's approach to serving disabled people, especially Māori and Pacific
	7) Racism as a root cause is examined superficially/informally

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Building pro-equity skills and capability	8) Use of data has improved over the past year, but more expertise and commitment is required

As a result of those findings, the report makes five recommendations:

1) Set a coherent direction for equity, demonstrated through a specific, time-bound equity goal
2) Develop a pro-equity performance framework
3) Develop and apply pro-equity decision-making principles for use by ELT
4) Build Māori and Pacific workforce and health equity capability
5) Continue to build and use formal mechanisms for partnership and participation

4 PRO-EQUITY WORK PROGRAMM

Considering the findings of this Report CCDHB executive are now developing a Pro-Equity Work Programme. The Work Programme will outline the steps to be taken with a clear focus on gaining organisational commitment, not only of the Governance, but also across the organisation, our provider partners, our communities and other key stakeholders including unions.

Gaining organisational commitment from the outset will be critical for the proposed pro-equity shift is to have any chance of success. Senior management, clinical leaders, key partners and influential stakeholders will need to be on the same page around vision, principles, commitment and practical implementation.

The Work Programme will be developed for presentation to the Health System Committee in June 2019.

The Work Programme will reflect an integrated approach and will reflect the following plans:

- Taurite Ora – Maori Health Plan, CCDHB (In Draft)
- Enabling Partnerships: Sub-Regional Disability Strategy 2017 – 2022 Wairarapa, Hutt Valley and Capital & Coast District Health Boards
- Toe Timata Le Upega Pacific Action Plan 2017–2020
- CCDHB Health System Plan 2030

Baker Jones

Capital and Coast DHB Pro-equity check-up

Prepared by Gabrielle Baker and Bryn Jones
Baker Jones
January 2018

Introduction

From October to December 2018, Baker Jones undertook a pro-equity check-up of Capital and Coast District Health Board (CCDHB) to assess how well the organisation is embedding a pro-equity approach into its work.

This report provides our key findings and a set of recommendations for how Capital and Coast DHB can take action towards being a pro-equity organisation – an organisation committed to doing all it can to achieve health equity with urgency.

In making our recommendations, we have selected the critical areas for focus, rather than identifying every potential activity. The latter approach might create a long to-do list to keep the DHB busy but wouldn't necessarily have the best impact.

There is no single checklist to assess the equity approach taken by an organisation. Our approach has drawn on DHB information and documents, engagement with staff, health equity literature, health sector guidance documents and our own expertise to provide a clear-eyed view on where the DHB is at now, and provide practical advice on how to proceed in 2019.

A feature of a pro-equity approach is that it works to address the imbalance between those who are most and least privileged. So, to best understand how CCDHB works, we looked particularly for evidence of approaches that support Māori health, Pacific health and the health of disabled people. Because of the DHB's statutory obligations in the New Zealand Public Health and Disability Act 2000 and the health sector's use of Treaty of Waitangi principles, we paid particular attention to the involvement of Māori in decision making and service delivery.

What we did

In conducting the pro-equity check-up we had three main questions:

- What does CCDHB say it does about health equity?
- What actually happens?
- How does the DHB meet equity expectations and align with pro-equity practices?

Document review

We first collected information through a document review, which included DHB planning documents, reporting, terms of reference, Board papers, key strategies (some of which are sub-regional), organisational leadership and management, data, analysis and needs assessment, and staff orientation materials.

Interviews

Next, we held 16 interviews, mostly face to face with a mixture of DHB executive team members, members of external groups, PHO management and a Board member. The purpose of the interviews was to:

- test and confirm our understanding of what we saw in the document reviews
- get an understanding of whether the DHB's actions were aligned with its intentions (as articulated in the documents) from a range of perspectives
- identify other areas we should look into or consider in our pro-equity check-up.

The interviews conducted generally covered:

- CCDHB's approach to equity, and how well is it doing in achieving its equity goals
- Māori involvement in decision making and service delivery
- CCDHB's approach to Māori health, Pacific health and the health of disabled people
- CCDHB's approach to investment
- data and analytics
- rivers of inequity including the role of racism.

Surveys

We conducted three online surveys. Each had a slightly different focus and were sent to:

- CCDHB ELT members
- Senior (3rd tier) staff
- All staff (through the *Daily Dose* email newsletter).

The purpose of the surveys was to better understand the norms[1], culture and values of Capital and Coast DHB. The surveys were also an opportunity to compare what the DHB actually did (eg in engagement with Māori) with what it "said" it did (as identified in the document review). Some of the survey questions aimed to get views on potential actions to strengthen the DHB's approach to equity.

There were over 150 responses to the surveys we sent out. However there was a very low number of ELT respondents, therefore the ELT survey results are not included in our analysis.

More detailed reports on the interviews and surveys are attached as appendices to this report. The document review report is provided as an attachment.

Investment Workshop (SIP)

A workshop was held on Monday 10 December, 2018 – with more than 40 staff from the Strategy, Innovation & Performance (SIP) team. The purpose of this was to test the accuracy of our findings and the relevance of recommendations of the report. Workshop activities reinforced the themes of our pro-equity checkup, and highlighted that there is an awareness of the key issues, with actions already underway in some areas (but not consistently across the whole of the DHB).

What we found

CCDHB should build on what it is already doing and move from awareness raising and increasing knowledge about inequity to taking decisive pro-equity action.

CCDHB has taken some important steps over the past 18 months. These include:

- Recognising the need to improve and focus on CCDHB's approach to investment, data and analytics
- Developing a Māori health strategy (currently underway)
- Regularly including items on the agenda for CCDHB's statutory committee (the Health System Committee) that have equity content
- Increasing the voice of tangata whaikaha[2] through a regional sub-committee / caucus.

We also noted the willingness of staff at every level to take a pro-equity and anti-racist approach to their work and the value placed by staff on the contribution of the Pacific health and Māori health leadership within the organisation.

We were also told of the successes CCDHB has had in service delivery, such as improvement in oral health enrolment in Porirua for Pacific kids. This tells us when the circumstances are right, and equity is prioritised, CCDHB is able make progress.

[1] Norms are the unwritten rules that shape "the way that we do things around here".
[2] The term tangata whaikaha was used by people we interviewed to cover disabled Māori. It is also the term used in the Ministry of Health's Whaia Te Ao Marama (Māori disability plan) and for this reason it is the term we have used throughout.

While there are a number of positive aspects of the DHB's work, the report unapologetically focuses on where to next. Ultimately this means a focus on the hard work required to make improvements, accelerate change or even change course so that CCDHB is — across the provider and funder arms — consistently achieving equitable results.

In total we have eight findings, grouped into three key themes:

- *commitment and accountability,*
- *strengthening participation,*
- *building pro-equity skills and capability*.

Theme: Commitment and accountability

Finding 1

Good intentions are evident, but this must be translated into action.

"There has been a strong commitment to equity… but having to influence such a huge beast is another issue."[3]

CCDHB signals its intent to achieve equity through Board papers (especially when providing updates on Māori or Pacific health), key communications to staff (eg the orientation material), and annual planning documents. Staff almost universally report equity as a high priority through the surveys we conducted. But in interviews, while there was a split between those who thought ELT "got" equity and those who thought it didn't, almost everyone agreed there needs to be more action.

"ELT really get it, but we need to transfer that rhetoric into reality."[4]

In interviews, we heard a range of reasons why there is more discussion than action, but overall it seems that:

- There is growing knowledge of and discussion about health inequity, Māori health and Pacific health, and the role of racism in health but that this is not yet widespread throughout the DHB. A common narrative is that CCDHB is still in a socialising phase.
- CCDHB has developed tools (particularly in SIP) intended to help the organisation to plan or prioritise in a pro-equity way. It appears that these tools are not as consistently well understood as they need to be for their impact and use to be widespread. There are also areas (such as building the Māori workforce) in which progress might require different tools for leaders to use.
- Individual commitment is variable and there is not enough guidance to senior leaders and decision makers on what the right action would look like.

"*There's a certain amount of inertia in the system, despite people's best intentions, and staff are busy 'fighting fires' with little time to concentrate on pre-empting and avoiding them."*[5]

There is evidence staff 'on the ground' are particularly keen to see more done across the organisation as it strives for equity. The recently completed *People Strategy* shows enthusiasm for building a different organisational culture. However, there is no evidence that we saw of the organisation capitalising on the willingness of staff to act.

Amongst external interviewees and staff, in particular, there is a call for the DHB to

[3] Source: interviews
[4] Source: interviews
[5] Source: survey

	take action and a cynicism that this pro-equity review may be put 'on the shelf' and not lead to meaningful change. This is a legitimate concern, and one we share as we note that the competing demands on ELT members' time meant that some were not able to prioritise an equity-focused interview with us and most didn't complete the ELT survey.
Finding 2	**The organisation needs a coherent approach to equity.** Given its size, functions and budget, CCDHB's many moving parts make it hard to see a cohesive vision for equity. There are elements of a pro-equity approach evident, and data and analytics on health need and DHB performance have improved. But there is clearly more that needs to be done. All groups rated CCDHB's equity capability as very poor, with an average score of under 4 out of 10. *"I think much more could be done to improve equity in the services I manage. We don't have the tools or support to do this and am not sure how to access tools and support. It is not clear in this organisation how to do this."*[6] *"There is no infrastructure to operationalise an equity approach."*[7] Because a number of new tools have been developed and implemented in SIP, we interpret quotes like this as evidence that the impact of the tools has yet to be felt across the organisation, particularly in the provider arm. We also note that the tools that have been developed provide a necessary platform to better articulate and understand the equity challenge, but tools to turn this knowledge into action that the outside world would see, eg a commissioning framework, are yet to come. We also note that the DHB governance has indicated that equity is important. The Māori Partnership Board (MPB) has identified equity as one of its three priorities. The CCDHB Board responded by identifying one of its members as an equity champion. The impact of this is varied – it is obviously a necessary step but while there are superficial equity discussions recorded in the Health System Committee minutes and updates, the full Board's papers don't show a strong equity thread.

[6] Source: survey
[7] Source: interviews

Interviewees indicated ELT rarely include equity discussions in its meetings or decision making in a formal way. For example, there were three different stories told about the value placed on equity in funding decisions. These ranged from:

- explicitly describing approaches as "pro-equity". The example given showed a willingness to challenge the way funding had always been allocated to providers. However this was more about *partially* addressing inequitable funding rather than being truly pro-equity.
- having equity as a requirement of funding or planning templates (although templates we saw indicated these are not completed to a high standard)
- equity considerations having no impact on decision making.

"There's a lot of slogans flying around."[8]

CCDHB has committed to an "investment" approach (which for CCDHB means moving to an approach where all money spent can be tracked to health outcomes). It has also increased its focus on a "life course" approach.

However, understanding of what these approaches mean, and how they can be used in a "pro-equity" way, is not consistent across teams. For example, the term "life course" approach was used inconsistently in the papers we reviewed. It was predominantly used as a way to explain investment at different ages and stages rather than the more accepted, and equitable, meaning of a life course approach, investing specifically in the early years to get maximum population health gains. This suggests the need to both build knowledge of staff and equity capability across the organisation.

There were concerns expressed by some that the DHB was still investing in the hospital at the expense of community services that might have more of an impact for Māori and Pacific children and young people.[9] While it was outside of the scope of this project to look into this assertion specifically, the SIP workshop highlighted that funding approaches still vary across the DHB's funder-arm and provider-arm limiting the DHB's opportunity to address inequities. In our view, looking further at investment is warranted given the principle that an organisation's values are demonstrated in how it spends money.

The performance expectations on staff appear varied and there is little guidance given to hiring managers on how to assess staff for competence in terms of a pro-equity approach. While there are signs that specific teams or disciplines are making progress (eg new graduate nurses), these are siloed and not consistent across the organisation.

[8] Source: interviews

[9] An example given to us was the DHB's breastfeeding service.

Finding 3	**To deliver on the Board's expectations there needs to be clearer accountability for equity at every level of the organisation.** *"We expect Boards to be highly engaged and to hold Chief Executives and management tightly accountable for improved performance within each DHB, particularly in relation to equity of access to health services and equity of health outcomes."*[10] While the expectation on DHB Board to hold their organisations to account for equity has been made explicit by the Minister of Health, there is still a perception that the real focus is on financial performance. "'*We have a [budget] deficit' is the main part of the discourse."*[11] *"There might be good intentions but the results don't show that."*[12] To get the gains it wants to see, CCDHB must hold its leaders to account for equity, and currently it doesn't. Where an equity focus is evident eg in job descriptions, it appears to be considered as secondary (at best) to 'overall performance', rather than as underpinning quality/ performance measures.

[10] Hon Dr David Clark, Minister of Health's Letter of Expectation to DHBs (2018/19)
[11] Source: interview
[12] Source: interviews

Theme: Strengthening participation

Finding 4

There is a focus on getting the "right voices around the table" but this puts a lot of pressure on a small number of individual experts. More should be done to grow, embed and realise the benefits of this expertise.

The health sector is designed to support community input into local decisions. CCDHB has given expression to this formally through the MPB, the Sub-Regional Pacific Group and the Sub-Regional Disability Advisory Group (and there is a Māori caucus that sits underneath this group).

While there isn't clarity about how these groups and their views are routinely incorporated into DHB business, we know from a number of interviews that representatives of the MPB and the Sub-Regional Pacific group are an important part of decision making by the Health System Committee[13]. While this is positive, there is room for this to be strengthened.

We found that while there are mechanisms, like these groups, to ensure input from "diverse" voices, the DHB relies on a small number of individual experts, who each put in a great deal of work. This creates a risk of burnout, particularly where the issues raised by these experts may not be directly responded to or formally weighed up by decision makers, or seen as valuable. It seems to us that despite good efforts there is a risk that CCDHB could lose access to the very expertise that allows them to take a truly pro-equity approach and support partnership with the community. Strengthening connections to local experts with lived experience of disability, for example, supports better involvement of the local community in decision making and service design and (re)orients services in line with health need.

Taking Māori expertise as a case study, we heard in interviews and saw in documents that the MPB has had some impact at a Board level. The MPB identified equity as one of its top three priorities, which led to the Board appointing an equity lead from amongst its membership. But the MPB only gets 15 minutes on the Board agenda every six months, so it is not surprising that MPB's role is not visible to everyone in the funder arm of the DHB, let alone the provider arm. None of the 'senior staff' or 'all-staff' groups surveyed indicated that they use the MPB as a way to involve Māori in decision making.

A few 'hygiene' factors were noted during the review, which give the impression that the "right voices" aren't embedded into the organisation. For example, the MPB

[13] discussed in interviews.

information on the CCDHB website[14] is out of date and we weren't able to access copies of the Sub-Regional Pacific group's minutes[15]. This is not a criticism of the individuals who support the groups, but suggests that the groups could be given more priority within the organisation.

Looking at the operation of the DHB, rather than governance or advisory groups to the Board, a number of people we interviewed talked about the importance of strong Māori, Pacific and disabled voices 'at the table'. There is a lot of praise for the individuals in these roles, and they're credited with improving the way ELT operates over the past two and a half years. In practice this led to a reliance on those in Māori and Pacific leadership positions to raise equity issues at the ELT table and ensure an equity approach in projects.

"Māori and Pacific leaders in the organisation have lived experience that is not available to all of us in the same way."[16]

The document review showed us that the DHB expects governance for SIP-led projects to have an equity focus. While this sounds really positive, and could even provide an opportunity for the community to be involved, in practice this leads to the Māori and Pacific teams invited to be part of just about every project.

"Tokenism is so heavily embedded throughout our organisation that it is a very difficult thing to constructively make a difference."[17]

There were a small number of examples of successful equity initiatives identified by staff in the survey, and they largely related to activities of the Māori and Pacific teams. For small teams this is a workload that is impossible to carry if they are also going to do justice to the governance roles in SIP-led projects.

"The Maori and Pacific support units do not have sufficient staff to support their patients and do their job effectively."[18]

The SIP workshop provided tangible examples illustrating the value that the Māori and Pacific teams add is apparent when they are closely involved in projects (such as the 'optimal wards' initiative) but that those teams are inadequately resourced to consistently be able to add the value that they have the potential to offer.

[14] https://www.ccdhb.org.nz/our-services/a-to-z-of-our-services/maori-health/maori-partnership-board/
[15] We requested these on a number of occasions but they were not able to be tracked down for us.
[16] Source: interview
[17] Source: survey
[18] Source: survey

Finding 5	**More must be done to build the Māori and Pacific health workforce at CCDHB.** *"[There are] not enough Maori employed as clinicians and senior management."*[19] *"[We need] more Maori and Pacific practitioners at every level of the organisation."*[20] Building the Māori health workforce is a priority for the Māori Partnership Board. Ensuring the health workforce reflects the community is also a feature of *Toe timata le upega.* Staff who responded to the surveys also highlighted the need to build a Māori and Pacific workforce. Māori staff and Pacific staff who answered the survey rated the DHB as less than 2.5 out of 10 for appropriate ethnic makeup of staff and senior leaders. While workforce makeup is a widely recognised equity issue, it has not been responded to in a way that has had a tangible impact across the DHB as a whole. We were not provided up to date workforce figures, so as a default we relied on the FTE information available in the DHB's latest annual report. These show Māori make up about 5.7% and Pacific people around 6.1% of the DHB's workforce. When we asked people about staff in their area no one was able to provide us with comprehensive ethnicity data. Generally speaking, the Māori health team appear to hold the best information about workforce. *"Lack of affirmative recruitment strategy for Maori and Pacific staff (apart from graduate nurses) Lack of focus from all services about this."*[21] We heard (from two thirds of interviewees and a large number of survey respondents) that workforce development for Māori and Pacific is essential. There were particular calls for more support from HR to make this happen, as well as more connection to tertiary training facilities (to provide a better connection to the "pipeline" for health professionals). SIP workshop attendees noted that despite the best of intentions, and relatively high self-rating of cultural competence from Pākehā staff, patient feedback reveals that the cultural competence of staff is far from ideal. Growing the Pacific and Māori workforces (and particularly for frontline staff) is a way to improve the cultural competence of the workforce beyond what formal training can offer.

[19] Source: survey
[20] Source: survey
[21] Source: survey

Finding 6	**There are significant opportunities to improve CCDHB's approach to serving disabled people, especially tāngata whaikaha and Pacific people with disabilities.** *"The organisation really cares about enabling people with disability to be full participants."*[22] While the government has set guidance for the public sector around meeting the needs of disabled people through the Disability Strategy (2016) and documents like Whaia Te Ao Marama (2018) DHBs all vary as to how they incorporate these into their work. The Sub-Regional Disability Strategy, which Capital & Coast shares with Wairarapa and Hutt Valley DHBs, provides some clarity about how CCDHB is responding to the needs of its population. When we asked about the strategy though, we found little evidence of it being operationalised across CCDHB. *"The disability pathway was developed on a minimal budget and has not been well integrated due to insufficient funding – it has not been prioritised."*[23] There was not a lot of information volunteered in the interviews or surveys about the DHB's approach meeting the needs of disabled people. People were unable to tell us how they were performing for disabled people generally, and so there was even less they could say about performance for tāngata whaikaha or Pacific people with disabilities. This is surprising, given the explicit reference in the Sub-Regional Disability Strategy to DHB executive teams evaluating and improving the effectiveness of services for Māori people with disabilities[24], and the evidence that intersectional analysis (looking at the range of factors and identities that intersect for disabled people) is required[25]. Consistent with the DHB's approach to equity, overall there were good intentions expressed in interviews but no real evidence of the DHB having strong engagement with disabled people. The existence of a sub-regional disability advisory group is positive but there is concern that it doesn't provide enough of a mechanism for tāngata whaikaha or Pacific people with disabilities to influence the business of the DHB. The Māori caucus/ sub-group is still in an establishment phase and few people we interviewed were aware of its existence. It would need significantly more support, including funding, to realise its potential role in addressing the current imbalance. We understood from our interviews that discussions between the Māori caucus/ sub-group and the DHB were underway.

[22] Source: interview

[23] Source: survey

[24] Sub-Regional Disability Strategy (Wairarapa, Hutt Valley and Capital and Coast DHBs, 2017-2022), page 30.

[25] **Whānau hauā: Reframing disability from an Indigenous perspective**. Accessed 10 December 2018. <http://www.journal.mai.ac.nz/content/whānau-hauā-reframing-disability-indigenous-perspective>.

Theme: Building pro-equity skills and capability

Finding 7	**Racism as a root cause is examined informally or superficially, although there is a groundswell of support from staff for anti-racist activities** *"We have the odd conversation about institutional racism but probably not a lot."*[26] The connection between racism and health is well established. And through the People Strategy development, staff raised it as an issue they wanted to be part of addressing. The staff surveys further suggest that racism (and its impact on health) is a topic that is discussed within CCDHB, with a number of survey respondents identifying 'structural' or 'institutional' racism in the way that the DHB goes about its business. Across all interviews it was apparent that racism was a topic discussed in some form. *"Institutionalised racism exists – the system continues not to meet the needs of Maori evidenced by not actively ensuring equity is addressed by appropriately resourcing services for Maori."*[27] There were examples given of inaction in the face of demonstrated need given in the interviews for example, but this wasn't usually acknowledged as a manifestation of institutional racism. The action to address racism however, is limited. *"A lack of understanding about the neoliberal, postcolonial framework is at the foundation of the DHB. Without understanding the how & why the DHB is the way it is, any effort to right these health disparities will be temporary at best."*[28] There are, however, solid 'raising awareness' type actions underway – with a number of people referring to Dr Camara Jones' *Gardener's Tale* and the leadership shown by the Acting CE in sharing it (in the *Health Matters* newsletter). *"Inequity drops out of racist attitudes and doesn't just happen on its own account."*[29] Racism as an individual behaviour or "unconscious bias" was also discussed, with some concerns about the actions taken by individuals. No specific details were

[26] Source: interviews
[27] Source: survey
[28] Source: survey
[29] Source: interview

	given on this but the lack of appropriate ways to escalate or complain about the behaviour was noted in the survey. There was also some indication that senior leaders have had to 'call out' racist behaviours but this appears to be an exception.
Finding 8	**The use of data has improved over the past year, but more equity expertise and commitment is needed to incorporate this focus into all aspects of DHB business.** *"Frankly, we haven't had the data."*[30] In the past 18 months CCDHB has put significant effort into data and analytics within its funder arm. This has started to reap benefits with more sophisticated information being presented in Board and committee papers. As an example, we saw improvement in the way the DHB has used and presented data in the System Level Measure (SLM) plans for the past two years. When we looked at the newer, improved, plan we still noticed some lost opportunity and examples where the data didn't make sense. While the SLM doesn't allow DHBs to showcase their analytical capacity it can give some insight into whether the basics are right and our assessment is that things are moving in the right direction, but more development is needed. While we were consistently told that data and analytics has improved over the last year, there was also a sense that improvements are not yet embedded across the organisation. Just over half of survey respondents 'rarely or never' look at Māori health data in their work. There were also comments that data wasn't visible in the hospital or provider arm. And in interviews a number of examples were given of information gaps that impeded a pro-equity approach (eg in what was presented to the Board or discussed at team meetings). Ethnicity data quality continues to be an issue for CCDHB (as recorded in MPB minutes). *"A whole lot of data we – and the Ministry – collect isn't broken down by ethnicity."*[31] Naturally enough, SIP have been leading the charge to improve the skill level of staff (primarily through smart recruitment choices) and provide access to tools (like Qlik). However, there appears to still be gaps in the level of expertise amongst DHB decision makers about firstly what constitutes good data and analytics and secondly how to use data to best effect.

[30] Source: interview

[31] Source: interview. We note it is likely here that it is meaning the routine analysis of data rather than data collection.

	Furthermore, good data and analytics is only as “pro-equity” as the frameworks that underpin them. The SIP workshop highlighted a concern about the unrealistic belief that ‘better data’ is a solution in and of itself. SIP’s move towards System Dynamic Modelling (looking at impact across the whole of the system) and ‘prescriptive’ rather than ‘descriptive’ analytics is positive but are not pro-equity in and of themselves. We found a few examples of inaccurate or poorly presented data in the relatively small sample of documents we reviewed. We also heard that the MPB has also given feedback to staff on data analysis. It seems that there are steps in place to improve this situation, because while governance and advisory groups need to be able to critique data, the small issues are most appropriately picked up at an operational level.

Preliminary recommendations

Based on our findings, we think it is important that CCDHB prioritises the development of a clear approach to equity that everyone in the organisation – from the Board to all staff – can understand and take tangible steps to demonstrate commitment.

We have five preliminary recommendations, subject to further discussion with the DHB. If the DHB actions all five recommendations within the next 12 months, then it will be considerably better equipped to address inequity in the district and will be further along the path of being a pro-equity, anti-racist organisation.

This report is grounded in reality. We know that the DHB is an organisation in transition, and that much of its work is determined centrally. But the recommendations are centred on the core business of the whole organisation (and critically, not just the Māori and Pacific teams). We recognise that implementing these recommendations isn't just about goodwill, and that when we are talking about 'commitment' we are also talking about the need to prioritise funding to make these a reality.

Rec 1	Set a coherent direction for equity, demonstrated through a specific, timebound equity goal
Rec 2	Develop a pro-equity performance framework
Rec 3	Develop and apply pro-equity decision-making principles for use by ELT
Rec 4	Build Māori and Pacific workforce and health equity capability
Rec 5	Continue to build and use formal mechanisms for partnership and participation

Rec 1: Set a coherent direction for equity, demonstrated through a specific, timebound equity goal

While there was a stated commitment to equity there needs to be an unequivocally clear pathway for the organisation to achieve equitable outcomes that is well understood across the organisation. Based partially on the IHI White Paper Achieving *Health Equity: A Guide for Health Care Organizations,* we recommend that CCDHB's ELT develop a unifying equity goal.

The equity goal would be:

- unambiguously focused on achieving equity (not just "improving" equity)[32]
- visible to all staff and the public
- endorsed by CCDHB's Board
- unifying, in that it resonates across the organisation
- time limited (eg with a 5–8 year horizon).

There are different approaches ELT could take to this goal. The goal could approach equity from the perspective of access/ utilisation, it could focus on a specific sub-population group (eg the first 1000 days), or be a more general goal. Each approach has pros and cons but whichever approach the DHB decides on has to:

- resonate locally
- address the imbalance between those who are most privileged and those who face the greatest barriers to health
- be evidence informed.

We recommend CCDHB start by focusing on addressing ethnic health inequities. These (and in particular, Māori health inequities) are the most compelling and consistent health inequities in Aotearoa. Furthermore, a focus on indigenous and ethnic minority groups also indirectly captures other parameters of health inequity (such as disability, socio-economic disadvantage, incarceration, educational 'non-achievement' etc). This is because of the disproportionate burden of disadvantage bestowed on Māori and other ethnic minority populations by colonisation and structural racism. Ethnic inequities were also the equity issues most frequently raised by staff in surveys.

It is widely recognised that the DHB's equity expertise/ capability is limited, and the development of a meaningful equity goal should additionally be supported by external health equity expert input.

[32] 'Improving equity' is language used in the health sector to mean 'reducing inequity'. This language is misleading, in that equity is binary, and cannot be 'improved'. The language also suggests that there is an acceptable level of inequity – which is not consistent with CCDHB's aspirations of being a pro-equity organisation.

Rec 2: Develop a pro-equity performance framework

Translating intention into action is an area for development. CCDHB signals that equity is important yet there is a lack of corresponding action, resources, time or effort dedicated to make this happen. This lack, coupled with increasing expectation on Boards to hold management to account for equity performance, means that the DHB need to put in place specific tools to drive and demonstrate pro-equity action.

We recommend developing an organisational pro-equity performance framework, with a set of indicators, which could be used to both provide a mechanism for the CCDHB Board to hold management to account and to give guidance to staff on what is expected of them.

The framework could leverage off other equity tools, eg the Ministry of Health's *Equity of Health Care for Māori: A framework*[33], or the equity tools being regionally developed with TAS. It would need to consider all aspects of the DHB's role (including the performance of the hospital, performance of contracted services, influence and role in root causes of inequity, commissioning practices, community engagement, appropriate workforce and organisational capability). CCDHB has already signalled an interest in developing an equity-focussed commissioning framework. This could be informed by the overarching organisational performance framework.

Responding to the People Strategy's call for key performance indicators (KPIs), relevant measures from the framework could be selected as 'pro-equity KPIs' for the CE and EMT as part of their annual performance agreements and reviews.

Our assessment is that CCDHB will require external equity expertise to support work such as:

- the development of KPIs that are relevant to the role of each EMT member, to enhance individual and collective accountability across the executive team
- the selection of measures for a performance framework
- pro-equity and anti-racism training, initially for ELT but eventually for all staff. Such training could similarly support the Board's learning, and grow Board capability to hold the organisation to account for equity performance. This could build on introductory training sessions offered by Wellington Medical School (Otago University) in early 2018.

We also recommend greater emphasis be given to training in responsiveness to tāngata whaikaha and Pacific people with disabilities to help the DHB lift its performance.

Careful attention must be given to the selection of measures, to avoid unintended consequences like wasting effort on the wrong tasks, staff disengaging due to lack of progress, or inadvertently increasing inequity.

[33] https://www.health.govt.nz/publication/equity-health-care-maori-framework

Rec 3: Develop and apply pro-equity decision-making principles for use by ELT

CCDHB's executive team make funding and other operational decisions both collectively and individually within particular areas of responsibility. We heard that equity is discussed by ELT, but we were told this doesn't influence decision making in a formal way. We think this should change.

We recommend that the ELT put in place principles to make decisions in a way that is:

- transparent
- consistent
- explicitly pro-equity.

The principles themselves could be developed by ELT within the first six months of the year, to be put in place by 1 July 2019. Initially they could be used for collective decision making but over time apply to nearly all decisions made by ELT members.

The principles would include:

- **'procedural'** factors, like working within the DHB's budget or ensuring appropriate engagement with Māori communities, Pacific communities and disabled people – recognising this must include tāngata whaikaha and Pacific people with disabilities. Making explicit the need for engagement would reinforce the existing discourse in the DHB around having the right people at the table, and provide a useful way to turn this concept into some tangible action.
- the role of **evidence**, including good quality data and analytics, matched with a focus on health outcomes
- expression of the principles of the **Treaty of Waitangi** in health
- be ultimately underpinned by **equity**, which amongst other things means not just working to understand the equity impacts of decisions but making decisions based on what will achieve equity.

CCDHB already has a set of decision-making principles, primarily noted by SIP staff (not well known more broadly), which could be built on and examined by experts across the organisation and its advisory groups and committees.

CCDHB should ensure that decision-making principles are in keeping with Te Tiriti and over time become the norm for decisions throughout the organisation.There has been some criticism about these transparent decision-making approaches in New Zealand being applied only to new funding, or restricted to decisions about contracted services,[34] so it is important that the principles apply to decisions on resource allocation across both the provider and funder arms of CCDHB.

[34] Bloomfield A, Logan R. "Quality improvement perspective and healthcare funding decisions". BMJ. 2003; 327 (7412): 439–43

This recommendation responds to many of the concerns laid out in Finding 2 – particularly about a lack of infrastructure to embed a pro-equity approach, and Finding 4 – turning a 'seat at the table' into a tangible part of decision making. It also would demonstrate to staff that equity considerations are not optional, and provide a visible way for the DHB executive to demonstrate to the Board it is creating the foundations for equity.

Establishing transparent decision-making principles of this nature could also formalise the use of equity tools by staff. Having such a process also responds to some of the concerns raised in 2013 by Professor Don Matheson[35] about the decision-making principles used by CCDHB.

[35] http://publichealth.massey.ac.nz/assets/Uploads/From-Great-to-Good-Final.pdf

Rec 4: Build Māori and Pacific workforce and health equity capability

CCDHB needs the right skills to drive health equity, and a workforce that is fit for purpose (ie able to meet the needs of the population that it serves). This includes more Māori and Pacific staff (particularly in senior roles), and contemporary health equity expertise across the district's health workforce (not limited to only DHB staff). These principles also apply to advisory groups and committees that influence DHB decisions such as the HSC.

Although CCDHB has a *People Strategy* this does not explicitly address some of the most significant workforce concerns from an equity perspective. We recommend developing and implementing a recruitment and retention strategy focused on:

- increasing numbers of Māori staff
- increasing numbers of Pacific staff
- growing CCDHB's health equity expertise.

A recruitment and retention strategy would need to include these four features:

1. Building a better understanding of the CCDHB workforce. This must include routinely reviewing workforce data, broken down by ethnicity, and regular reporting to the Board. The Board have indicated a willingness to champion Māori workforce development, for example, and this would give them more visibility over progress.
2. Working collaboratively with community health providers, particularly Māori and Pacific providers to build the workforce. This will include sharing DHB training and development opportunities. It is also important to work with providers to avoid a perception of experienced Māori and Pacific staff in the community being 'head-hunted' by the DHB[36].
3. Recognition of the "pipeline" for workforce, and working with local and national education and training providers. However, this should be done thoughtfully as it can be used to avoid progress with other elements of a recruitment and retention strategy and can privilege the existing balance of health professional groups (eg nurses and doctors) over other health professionals (eg unregistered workforces, including less traditional roles such as a 'peer' workforce).
4. Attracting Māori and Pacific staff - by making CCDHB an attractive place to work and employer of choice. The people strategy lays a foundation for this, but despite positive signals, such as "*We actively seek to increase the numbers of Māori and Pacific staff in all roles and professions. Attempts to measure or manage organisational culture recognise and respect Māoritanga and actively engage with Māori in the development of initiatives and interventions"* no detail is given on how this will be done.
5. Better recognising the skills and lived experience required to serve the CCDHB community. This is necessarily more than ensuring "diversity" in the workforce, which as an approach

[36] This has been an unintended consequence of efforts to increase DHB Māori workforce in other regions.

doesn't address the system changes required or address the causes behind an unrepresentative workforce.

6. Active recruitment and targeting (eg interviewing all eligible disabled people, Māori and Pacific people applying for roles in areas where there are workforce pressures)
7. Offering career progression and ensuring that the makeup of management teams, including ELT, better reflects the CCDHB population.

It is likely that some elements of such an approach exist already (eg for new-graduate nursing recruitment), however there needs to be a consistent and coherent organisation-wide strategic approach.

To support this priority activity, we also recommend:

- More explicit expectations on all staff to work in a way that is pro-equity. The development of an equity competency, or more explicitly including equity as part of existing competencies, is a critical step in this, and would reinforce the pro-equity performance framework outlined in Recommendation 2.

- Providing more training and development opportunities to staff. We were given positive feedback on training offered by the Māori health development group. And we also know that sessions with Otago University Wellington School of Medicine were valued by staff. But these are not widely available to everyone. Examples of where training would help immediately are around use of data and equity analysis in the DHB provider arm. We also noted that in the staff orientation 15 minutes was allocated to a session on "living the Treaty" compared to an hour on speaking up for safety. This imbalance should be addressed - both by increasing the time allocated to the Māori health team in orientation and by offering more organisation-wide Treaty of Waitangi training.[37]

- Strengthening the role (and size) of CCDHB Māori and Pacific health teams. As we noted in the findings, the DHB relies heavily on those teams in regards to health equity (and in particular the demands of providing governance input for a wide range of projects across the organisation).

[37] We are aware of existing training but were told by interviewees that the number of places on these courses is very limited.

Rec 5: Continue to build and use formal mechanisms for partnership and participation

CCDHB clearly recognises the importance of formal relationships with the community – the MPB, the Sub-Regional Pacific Group and the Sub-Regional Disability Advisory Group and support for a Māori caucus to the disability advisory group are all evidence of this. However there is variable priority given to the groups, and there were differing views of their level of influence depending on who we asked.

We recommend building on these formal relationships in three ways:

1. Increase organisational support for all three of these groups. This needs to be done in a way that is sensitive to the different roles and functions of the groups. Although it is of most relevance to the MPB, the 2006 Te Puni Kōkiri guidance on Crown-Māori relationship instruments outlines some factors for organisations to consider in best supporting these critical relationships. These include:
    i. Ensuring staff have the right skills and experience to sustain good relationships.
    ii. Allocating sufficient financial resources to the relationship including funding to run the meetings, provide administrative support and travel assistance for members.
    iii. Demonstrating organisational commitment through appropriate training for staff (eg in cultural competence as well as technical skills and expertise such as Pacific health).

2. Strengthen the direct relationship between these groups and the CCDHB Board. There are already plans with the MPB to have a joint meeting with the Board, which is positive. In addition to these discussions, shared work priorities would be a tangible way to show how the relationship could work. The upcoming *Long Term Investment Plan* provides one opportunity for the Board, through the Health System Committee, to find new and better ways to embed these groups in deliberations and decision making.

3. Increase the number of Māori, Pacific and disabled people on all CCDHB advisory groups, including the citizens council and clinical council (or any future arrangements for clinical governance).

Appendices:

Interview analysis	Appendix 1
Survey analysis	Appendix 2
References	Appendix 3

Attachments:

Document review	

Appendix 1: Interview analysis

On 15, 22 and 23 November 2018 Baker Jones Ltd conducted sixteen interviews. Eleven were held face to face and the remaining five were held over the phone.

The purpose of the interviews was to:

- test and confirm our understanding of what we saw in the document reviews
- get an understanding of whether the DHB's actions were aligned with its intentions (as articulated in the documents) from a range of perspectives
- identify other areas we should look into or consider in our pro-equity check-up.

Who did we interview?

We aimed for a mix of senior DHB staff and and people outside the organisation who were well informed on how it operated. Broadly speaking our interviewees included:

- DHB ELT members or delegates (10)
- PHO Chief Executives (2)
- Advisory or Committee members (3)
- A DHB Board member.

What did we ask?

The interviews were semi-structured meaning we had a core set of questions but we also asked other questions based on what the interviewee said. The core set of questions covered:

- What is CCDHB's approach to equity, and how well is it doing in achieving its equity goals?
- How Māori were involved in decision making and service delivery.
- CCDHB's approach to Māori health, Pacific health and the health of disabled people.
- The approach to investment.
- Data and analytics (this question was asked in different ways depending on the person we interviewed).
- Drivers of inequity including the role of racism.

What did we find?

There was a view that the DHB, and in particular the executive leadership team (ELT), 'get it' with regards to equity. As part of this view there was a sense of both a real commitment and a maturing conversation about equity, particularly over the past three years. But slightly more people (5) said the opposite – that the DHB doesn't 'get it', and further doesn't seem prepared to engage the expertise it needs to build its understanding.

"*I would say the majority would have no idea what it [equity] means".*

There was consensus, however, that **regardless of the level of understanding within the DHB (and ELT particularly) about equity, there was conversation but not action** (13).

"*ELT really get it, but we need to transfer that rhetoric into reality."*
"There might be good intentions but the results don't show that."
"I can't think of any real activity that they're engaged in around equity."

In interviews we heard that while equity was discussed often it rarely featured as an element of decision making. Possible reasons for this proposed in interviews were:

- The impact of political will and central government direction (or lack of it), specifically the previous 9 years silence on equity (and a sense it wasn't okay to talk about) and now heightened visibility for equity but without clear guidance on what to do.
- Staff wanting to make a difference, and intent from the ELT but a "frozen middle" that is not equipped (perhaps because of a conservative mindset or a lack of tools or skills) to act.
- Lack of data (see below).
- The need for more resource (money, staff or time) to prioritise equity activity. (This was seen by some as a view that is used by the established hegemony/ status quo to maintain the current power structures which privilege a medical and even hospital approach).

In taking a pro-equity approach **a lot of focus is put on getting the right voices at the decision making table with varied success**. A number of people interviewed talked about the importance of having strong Māori, Pacific and disabled people's voices at the table. In practice this led to the Māori and Pacific ELT positions being relied on to raise equity issues at the ELT table. They were also credited with "radically changing" the ELT discussions over the past two and a half years. People spoke highly of both individuals.

There were observations made by a number of interviewees that the approach, while well intentioned, relied on a small number of highly skilled individuals. And despite this there was also

comment that there needed to be more Māori leadership engaged and more Pacific leadership throughout the organisation. One interviewer noted that if we talked to the people in the roles we'd learn they're "very lonely" and another noted that there wasn't a lot of depth (because of small teams) so while there might be someone capable of acting in their place if they were on leave, there weren't multiple people to draw from.

There was some comment about the expectation on Māori and Pacific teams to be involved in a large number of governance groups across the organisation (and the corresponding obligation on the teams to hand pick and prioritise because they're not resourced for that level of engagement). There was also some concern that the engagement processes with teams weren't set up for genuine participation by the Māori or Pacific advisors and that often things still needed to be escalated to ELT.

Across the organisation the ethnic makeup of management teams was noted as inadequate (not reflecting the population, with the sense that this meant equity wasn't on the agenda). The lack of a Disability manager in SIP was noted, as were the difficulties of recruiting someone with lived experience of disability into that role.

There were expectations that the external groups set up by the DHB would help to provide more diverse voices and expertise to the DHB. There was a sense of fairly **high expectations on the Māori Partnership Board (MPB)** – **despite the Board itself not providing a lot of time for the relationship** (5). This looks to be changing, as one interviewee indicated that the Board had agreed to a meeting with the MPB. This has yet to be seen though, and the general sense is that the Board would rather MPB engage with the statutory committees (specifically Health System Committee) and the MPB does not consider that appropriate.

The use of **the sub-regional pacific group is a source of strength for the Pacific team and DHB overall**.

Racism as a determinant of inequity is sort of talked about within the DHB (16) , **but it usually done so in a way that is informal and superficial**.

"*There is not enough insight yet about what racism really looks like."*
"We would have the odd conversation about institutional racism but probably not a lot."
"No evidence of understanding or addressing racism."
"They are constantly apologising which means they don't understand it – stop apologising and start doing something."
"*Inequity drops out of racist attitudes and doesn't just happen on its own account."*

There was enthusiasm for the CE's move to raise discussions on racism by sharing the *Gardener's Tale* by Dr Camara Jones in the staff newsletter. This was seen as a positive move by other ELT members, but it was noted that there wasn't a lot of feedback from staff, when it would have been preferable to have wide ranging discussions as a result.

"Is it racism or is it just defensiveness."

There were examples given in interviews of institutional racism as seen through the eyes of interviewees. The examples were of inaction in the face of need (eg around oral health) and of providers being singled out (eg through under-funding). There were also some (rare) examples of personally mediated racism or discrimination which were called out by ELT members.

Workforce development is seen as a critical issue but action to address the low numbers of Māori and Pacific health professionals is light (11).

"More should be done to make sure the workforce represents our population".

Current workforce demographics are seen as a barrier to progress with equity. Workforce is also seen as a top priority for the Māori Partnership Board and the sub-regional Pacific group. But the DHB has no obvious strategy to address this, which concerned a number of interviewees. There is some success in the area of new graduate nurses and some allied health professions but this is not systematic or organisation wide.

There is interest in training to upskill all the workforce to do better in terms of equity (6) but a reliance on the Māori and Pacific teams to provide or source this. Current training isn't seen as adequate and more is needed particularly around equity, cultural safety and cultural competence. Treaty training is offered by the Māori health team and people gave really positive feedback. But the team can only take a small number of people each year for this training and there is a sense that as long the burden to provide this training falls on the Māori health development team it isn't owned by the whole organisation in a way that would lead it to be well resourced.

HR need to provide more support to help recruitment and retention of Māori, Pacific and disabled staff. This includes providing advice on recruitment strategies and affirmative recruitment.

Disability issues aren't given the prominence you'd expect based on the sub-regional disability strategy, but there is nevertheless an interest in doing "something" (4).

"The organisation really cares about enabling people with disability to be full participants."
"There is a huge deficit in what tāngata whaikaha are getting."

There was recognition that services for disabled people were variable across different parts of the hospital but there isn't tracking of health outcomes for disabled people. There was even less on the intersection of disability and other privilege or disadvantage (eg there was a sense that disabled people are a homogenous group).

Data and analysis for equity is improving but it clearly hasn't been a strength to date (10).

"Frankly, we haven't had the data."

It is widely recognised that before SIP was set up there was almost no analytical capacity within the DHB (although there may have been some capability within Compass PHO). Having good quality data and analysis is critical to having equity conversations and was seen as a cornerstone in a pro-equity commissioning approach, for example.

The way that information was analysed in the past was criticised by a number of interviewees, including concerns that previously the DHB was comparing figures for its Māori population with the total population (not the non-Māori population). There is a sense that this has been rectified although reporting by ethnicity isn't standard across the DHB.

A couple of interviewees used Trendly data as an example to effectively convey differences in health outcomes. Trendly was taken to the Board –who have seen Māori data compared to non-Māori before but what was seen as particularly useful was seeing how well the DHB was doing for its Pākehā population (a sea of greens and orange lights on a dashboard) compared to the orange and reds for the Māori population. The use of dashboards, and the QLIK system were spoken of positively by a number of interviewees.

"Don't tell me your values, show me your budget." – Joe Biden[38]

Investment is a critical component of a pro-equity approach and **there was recognition in interviews that money needs to be spent differently** (15) **but the preference is to focus on new funding not on disinvestment or shifting current spending** (5).

The DHB is moving to an investment approach, which means according to interviews that they are looking to pay for outcomes, not fund on FTE or other inputs.

The DHB is wanting to be more transparent in its funding and investment and is working to be more transparent and fair in funding Māori and Pacific General Practice services, for example. There is also more scrutiny on how money is being spent (in line with equity) from the Board. Some funding decisions that go to ELT also need to consider equity, but this wasn't consistent and wasn't the case for other funding approvers (eg the capital committee).

"'*We have a deficit' is the main part of the discourse."*
"People talk about disinvestment a lot and actually it doesn't happen a lot."

There was a sense that some services could be offered in the community but for a range of reasons (including a perception that the hospital prefers to prop up its own provider arm services) this didn't happen (oral health was regularly given as an example here).

[38] One interviewee referenced this quote from Joe Blden when noting that the talk about equity is not matched by the way in which resources are allocated.

“There are a lot of slogans flying around.”

While some people recognised the ideal situation was to move money out of the hospital/provider arm, there were five interviewees who saw moving money out of the hospital as prohibitively difficult. For this reason there is a view that equity considerations and approaches like ‘simplify, intensify’ should only apply to new funding (not existing services).

Simplify, intensify has a number of fans throughout the organisation and is seen as code for equity and targeting. Although only discussed by a small number of interviewees, those who discussed it demonstrated enthusiasm for the approach but were unable to clearly articulate how it supports equity.

Appendix 2: Survey analysis

Baker Jones Ltd conducted staff surveys during November 2018.

The purpose of the surveys was to better understand the norms, culture and values of CCDHB. The surveys were also a chance to test how well what the DHB actually did (eg in engagement with Māori) matched with what it said it did (as identified in the document review). Some of the questions in the survey aimed to get views on potential actions to strengthen the DHB's approach to equity.

Three groups were surveyed (see table below) and surveys were slightly different for each group, however there were core questions we asked of all groups, and this summary focuses predominantly on those elements of the surveys. There is no analysis of the ELT survey as there were only two respondents – despite several reminders being circulated to ELT and extension of the survey closing date.

Group Surveyed	Number of responses
Executive Leadership Team (ELT)	2
Senior Staff (SS)	54
All Staff (AS)	96

What the surveys told us (summary)

The survey responses paint a picture of an organisation that has a stated priority focus on health equity, but no clear direction to achieve this. There is a sense that the high level commitment to health equity falls short of ensuring that processes set an expectation of equitable outcomes and do all that can be done to address inequities in health outcomes.

Staff almost universally report equity as a high priority in their work (although we recognise that there may be some sampling bias in terms of who chose to participate in a 'pro-equity' survey). On the other hand, **staff rated the equity capability of CCDHB overall as extremely poor**, with somewhat better equity capability and in the teams that they work in, and for the respondent's own capability. Although the pattern was very similar across all staff, this was exaggerated for Māori and Pacific staff.

Monitoring progress towards health equity was predominantly viewed through a health outcomes lens. There was also, however, significant recognition of the need to ensure an equity focus in the utilisation of services, and the ethnic make-up of CCDHB staff and decision-making groups.

There were **very few examples of successful equity initiatives** identified, and where these were noted, they largely related to activities of the Māori and Pacific teams. There was a common view that these teams are inadequately resourced, and that overall the organisation has a problem to address in terms of Māori and Pacific staff numbers - particularly in senior roles which have genuine influence on the way that the organisation operates. Once again, this pattern was exaggerated in the responses of Māori and Pacific staff.

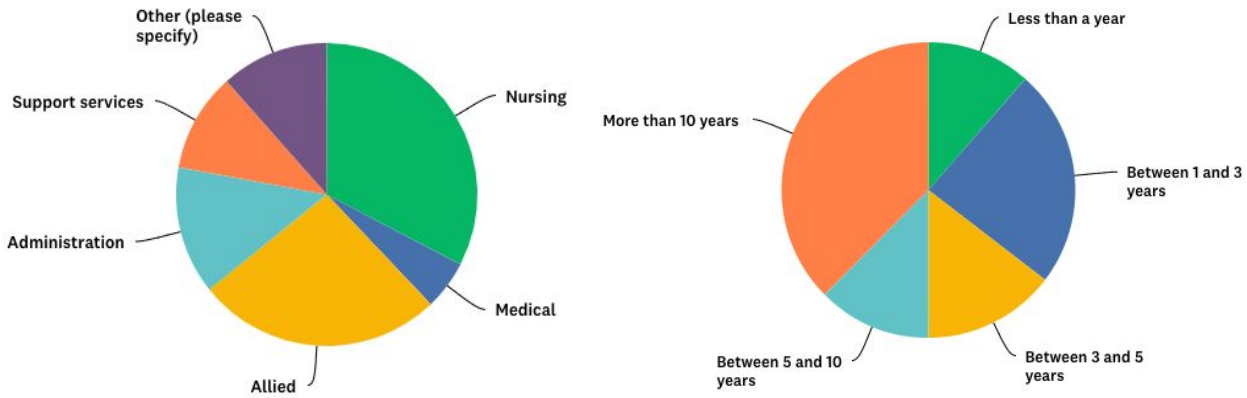
Racism (and the impact on health) appears to be a topic that is discussed within CCDHB with a number of survey respondents identifying 'structural' or 'institutional' racism in the way that the DHB goes about its business. Racism discussions seem to be at a superficial level at best, and there was variable understanding of the impacts of racism on health, with a dominant focus on the impacts on health ***care*** and individuals experiencing interpersonal racism that impacts their care.

Who participated in the survey?

Whilst very low ELT response rates meant that we are not able to include any analysis of the ELT survey in our report, the participation from other staff (and senior managers in particular) suggests that **health equity is an authentic concern and priority focus of staff**, at least for those who are not on the ELT. There may be valid reasons for the low participation rate amongst ELT members (it is a busy time of year, many are in 'acting' rather than permanent roles, etc), however it must be noted that this gives the impression that the executive leadership do not collectively view equity as a high priority. This sentiment was reflected in a number of survey responses that indicated equity considerations often give way to other pressures and that this is, at least in part, related to an inadequate understanding of health equity, its drivers, and what can be done to drive equitable outcomes.

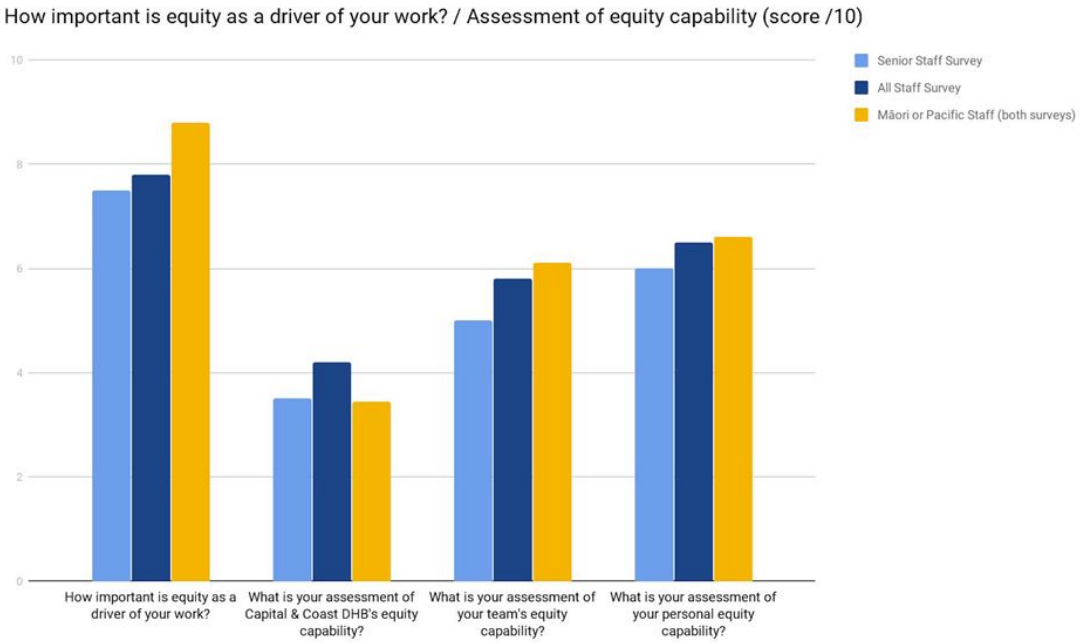
Overall, approximately 17% of respondents identified as Māori, 6% as Pacific peoples, 75% as NZ European, and 15% as 'other' ethnicity. These do not add to 100% because some respondents identify with more than one ethnicity.

Of the respondents to the All Staff survey, 50% have been at CCDHB for 5 years or more, and of those employed in the past year, the majority recall being asked about health equity and responsiveness to Māori in their interviews. The chart below shows the mix of role types of respondents - with approximately one third in nursing roles, and one quarter in allied health.



Breakdown of role type and length of service of staff survey respondents

Mismatch between commitment and capability



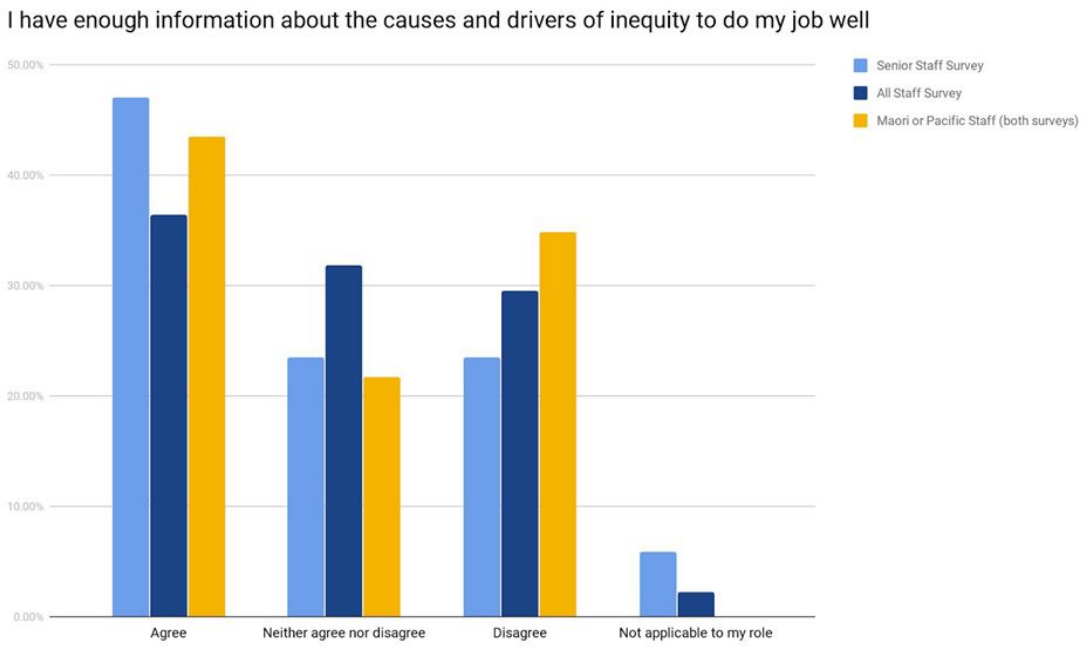
"How important is equity as a driver of your work?"

Overall respondents saw equity as very important in their work, with an average response of almost 8/10. Whilst the range was from 1 to 10, only five of 121 respondents to this question gave a score of less than 5/10. Māori and Pacific staff (across both groups) ranked equity as even more important with an average score of 8.8/10.

"What is your assessment of Capital & Coast DHB's equity capability?"
"What is your assessment of your team's equity capability?"
"What is your assessment of your personal equity capability?"

All groups rated CCDHB's equity capability as very poor, with an average score of under 4/10. On average people rated their team's and their own personal capability somewhat higher. This discrepancy was even more pronounced for Māori and Pacific staff.

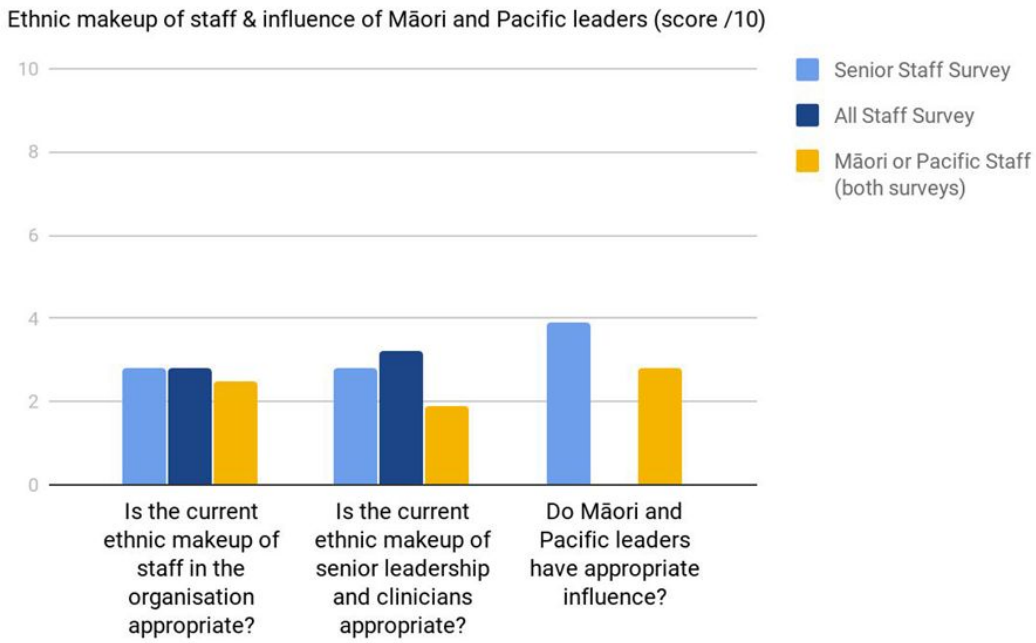
Mismatch between commitment and capability 2



"I have enough information about the causes and drivers of inequity to do my job well."

Approximately 40% of respondents (56/129) thought that they had adequate information about the causes and drivers of inequity to do their job well, with senior staff (and Māori or Pacific staff) more likely than other staff to believe that they are adequately informed.

Mismatch between commitment and capability 3



"Is the current ethnic makeup of staff appropriate for Capital & Coast DHB to carry out its role?"

"Is the current ethnic makeup of senior leadership and clinicians appropriate for CCDHB to carry out its role?"

CCDHB's *staff* and *senior leadership* ethnic makeup was not rated by any group as appropriate. Māori and Pacific staff gave the lowest average scores for these questions (2.5/10 and 1.9/10 respectively), with four of the five Māori respondents in the senior staff survey giving a score of **zero** for the appropriateness of the ethnic makeup of senior leaders.

"Do Māori and Pacific leaders at Capital & Coast DHB have appropriate influence?"

Only the senior staff survey asked about **the appropriateness of the influence of Māori and Pacific leaders at CCDHB**. The average score was just under 4/10, and once again, Māori and Pacific staff thought this less appropriate than others (just under 3/10 average rating).

Racism and Privilege

"What is your understanding of racism and its connection with health?"

There was a diverse mix of answers to this question. **Predominantly answers focused on racism in clinical settings and access to services** (limiting individual access to care) however a significant number identified structural (or institutional) racism and how it influences the way in things such as the way that healthcare is funded/ designed/ delivered, who provides services, who has the best (and worst) access to services, what types of services are offered, and in what locations.

"The current health system is a product of colonisation whereby structures where set up to privilege the colonising groups"

"People working with in the health sector unconsciously provide Maori, Pacific and other minority ethnic groups a lower lesser level of care. Our health services are built around the way we like to work and where we find it most convenient, many of us do not understand how difficult we make accessing health care in a timely way"

"Racism creates barriers to access and influences decisions around treatment options, care and outcomes"

"I have conversations with colleagues about the way that racism impacts health and what we can do to counter that impact."

Whilst it is impossible to gauge the depth (or otherwise) of these conversations, **approximately one third of respondents reported having regular conversations about racism**, one third "every now and then", and the remaining third rarely or never.

Racism and Privilege 2

"I have found ways in my work to actively address structural or institutional racism and its impacts."

This question was only asked in the senior staff survey - **approximately one half of all respondents (and two thirds of Māori and Pacific respondents) stating that they have found ways to address racism and its impacts**.

A few examples of discrete actions within specific areas were provided (such as reducing DNA's), however the failure to recognise racism, and the barriers to addressing it were noted by several respondents.

"Tokenism is so heavily embedded throughout our organisation that it is a very difficult thing to constructively make a difference."

"The organisation does not appear to be doing anything to address racism in the workplace."

"I do not have sufficient influence to make the necessary changes to have an impact." (Māori respondent)

"I think our staff are exposed to racism too and we don't notice it." (NZ European respondent)

"In your experience and opinion, which population(s) are most privileged by the way Capital & Coast DHB currently works?"

Almost all respondents recognised the impact of white privilege. Health literacy, transport, wealth (or 'class'), education, and ability to take time off work were also identified as factors that enable people to benefit from services offered by CCDHB.

"White middle class patients that can travel and take days off work to attend appointments."

"Well off white people"

"Non Maori, Non Pacific…. who understand how the system works and educated."

Monitoring, Engagement and Analytics

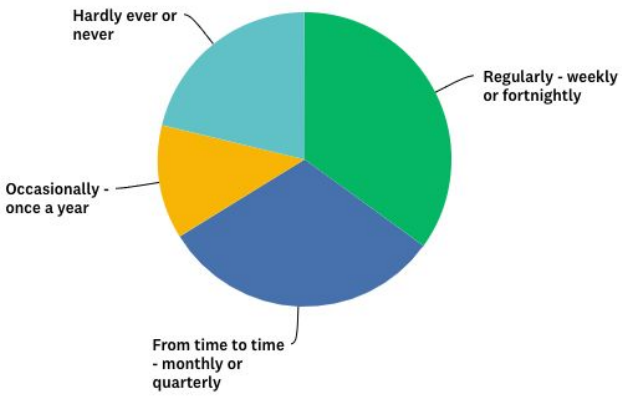
"There are various approaches that organisations take to demonstrate their commitment to equity. What should Capital & Coast DHB do?"

When asked about the approaches that CCDHB should take to demonstrate its commitment to health equity, the two most commonly selected answers were **"build better connections with Māori and Pacific communities"** and **"upskill staff (eg formal health equity or anti-racism training)"**, closely followed by "ensuring an equity focus in commissioning" and "increasing lived experience of inequity in decision-making groups (Māori, Pacific, and people with lived experience of disability)". Several comments suggested current CCDHB leadership for equity is suboptimal.

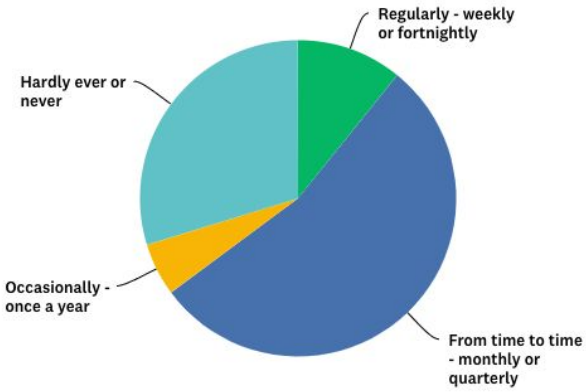
"Ensure this is led by ELT and on every agenda."

"How often do you engage with Māori health providers, health professionals, Iwi or communities in your work to achieve health equity, and/ or support whānau-centered services?"

Approximately one third of respondents engage weekly or fortnightly, one third monthly to quarterly, and one third infrequently or not at all with Māori stakeholders. Senior staff were less likely to have frequent (weekly or fortnightly) engagement.



All Staff Survey Respondents



Senior Staff Survey Respondents

"How often do you request or review data and analytics to see how well Capital & Coast DHB is performing for Māori in the district?"

Just over one half of respondents rarely or never look at Māori health data. One third say that they do so monthly or quarterly, and only 15% weekly or fortnightly.

Achievements and Barriers

"What do you think Capital & Coast DHBs biggest achievements in Māori health, Pacific health and health equity have been in the past 12 months?"

Most people responding to this did not feel that there were any examples of health equity achievements that they could identify, with answers such as "don't know", "unsure", "nil", "? Really not sure, this isn't very visible", "can't think of any" etc.

Achievements noted were CCDHB's attempts to recruit more Māori and Pacific nurses, the increased visibility of focus on health equity/ Māori health, and the strengthening of the Māori and Pacific Director roles (by having them focused full-time on Māori and Pacific health respectively).

"I think having the Director role become focused solely on Maori Health Development was a really good move. The development of the Maori Health Strategy is also a good start."

"Perhaps it's the recognition that health equity has to be more than superficial or a tick box."

"We are seeing a positive shift to thinking about what we do using an equity lens. This needs to be supported with direction on practical application."

"What do you see as the biggest barriers to Capital & Coast DHB making progress in Māori health, Pacific health and achieving health equity?"

The paucity of Māori and Pacific staff (particularly in clinical and senior management roles), lack of resources/ funding for equity initiatives, limited organisational capability, institutional racism, lack of buy-in from leadership, and the competing priorities of very busy staff were all identified as barriers to progressing equity at CCDHB. The strongest themes were the lack of equitable representation in the workforce, and the inadequate resourcing of the Pacific and Māori teams given the demands on them to provide health equity input across the whole of the organisation.

"Resources - the Maori and Pacific support units do not have sufficient staff to support their patients and do their job effectively."

"Lack of Maori staff in senior management/executive roles (outside of the Maori Health directorate). I am sure that if you counted the number up and then looked at the numbers of non Maori it would be embarrassing. Is there a strategy to recruit more Maori into these positions? If not why not? Why don't we have more Maori in these influential positions? How can we achieve health equity when we have little or no influence in the areas that are dealing with our people. Influencing strategy/policy is great but if we want to make a real change influence has to be at all levels including the operational levels. Our organisation creates barriers..."

Appendix 3: References

Bloomfield A, Logan R. Quality improvement perspective and healthcare funding decisions. BMJ. 2003; 327(7412) :439-43.

Burke, S., Bruno, M., & Ulmer, C. (2010). *Future directions for the national healthcare quality and disparities reports*. National Academies Press.

Came, H. (2014). Sites of institutional racism in public health policy making in New Zealand. *Social Science & Medicine, 106*, 214-220.

Chin, M. H., Clarke, A. R., Nocon, R. S., Casey, A. A., Goddu, A. P., Keesecker, N. M., & Cook, S. C. (2012). A roadmap and best practices for organizations to reduce racial and ethnic disparities in health care. *Journal of General Internal Medicine, 27*(8), 992-1000. 10.1007/s11606-012-2082-9 [doi]

Chin, M. H., King, P. T., Jones, R. G., Jones, B., Ameratunga, S. N., Muramatsu, N., & Derrett, S. (2018). Lessons for achieving health equity comparing Aotearoa/New Zealand and the United States. *Health Policy (Amsterdam, Netherlands),* S0168-8510(18)30131-3 [pii] Retrieved from https://www.healthpolicyjrnl.com/article/S0168-8510(18)30131-3/fulltext

Crown-Māori Relationship Instruments: Guidelines and Advice for Government and State Sector Agencies. (2006). Retrieved December 5, 2018, from https://www.tpk.govt.nz/documents/download/90/tpk-crmi-2006-en.pdf

DeSouza, R. (2018). Is it enough?: Why we need more than diversity in nursing. The Hive (23, 14-15).

DiAngelo, R. (2018). *White fragility: Why it's so hard for white people to talk about racism*. Beacon

Press.

Disability survey 2013. (2013). Stats NZ. Retrieved from https://www.stats.govt.nz/information-releases/disability-survey-2013

Equity of healthcare for Māori: A framework (2014). Wellington: Ministry of Health New Zealand. Retrieved from https://www.health.govt.nz/publication/equity-health-care-maori-framework

Gillies, T. D., Tomlin, A. M., Dovey, S. M., & Tilyard, M. W. (2013). Ethnic disparities in asthma treatment and outcomes in children aged under 15 years in New Zealand: Analysis of national databases. *Primary Care Respiratory Journal, 22*(3), 312.

What is the frozen middle, and why should it keep leaders up at night? (2017, May 02). Retrieved December 5, 2018, from https://www.theglobeandmail.com/report-on-business/careers/leadership-lab/what-is-the-frozen-middle-and-why-should-it-keep-leaders-up-at-night/article34862887/

Griffith, D. M., Mason, M., Yonas, M., Eng, E., Jeffries, V., Plihcik, S., & Parks, B. (2007). Dismantling institutional racism: Theory and action. *American Journal of Community Psychology, 39*(3-4), 381-392. 10.1007/s10464-007-9117-0 [doi]

Harris, R. B., Stanley, J., & Cormack, D. M. (2018). Racism and health in New Zealand: Prevalence over time and associations between recent experience of racism and health and wellbeing measures using national survey data. *PloS One, 13*(5), e0196476.

Hickey, H., Wilson, D. (2017) Whānau hauā: Reframing disability from an Indigenous perspective. MAI Journal 2017: Volume 6 Issue 1

Horsburgh, S., & Norris, P. (2013). Ethnicity and access to prescription medicines. *The New Zealand Medical Journal, 126*(1384), 7-11.

Jatrana, S., Crampton, P., & Norris, P. (2011). Ethnic differences in access to prescription medication because of cost in New Zealand. *Journal of Epidemiology & Community Health, 65*(5),

454-460.

Jones, Camara (2000). Levels of Racism: A Theoretic Framework and a Gardener's Tale *American Journal of Public Health. 2000;90:1212–1215*

Kaplan, R. S., & Norton, D. P. (1996). The balanced scorecard: Translating strategy into action Harvard Business Press.

Matheson, D. (2013). From Great to Good; how a leading New Zealand DHB lost its ability to focus on equity during a period of economic constraint. *Wellington: Massey University.*

McLeod, M., Blakely, T., Kvizhinadze, G., & Harris, R. (2014). Why equal treatment is not always equitable: The impact of existing ethnic health inequalities in cost-effectiveness modeling. Population Health Metrics, 12(1), 15.

Metcalfe, S., Laking, G., & Arnold, J. (2013). Variation in the use of medicines by ethnicity during 2006/07 in New Zealand: A preliminary analysis. *The New Zealand Medical Journal (Online), 126*(1384)

Ministry of Health. 2014. 'Ala Mo'ui: Pathways to Pacific Health and Wellbeing 2014–2018. Wellington: Ministry of Health.

Norris, P., Horsburgh, S., Cumming, J., & Tordoff, J. (2014). New Zealand health care Editorial–Prescription charges: Prescription charge increase in New Zealand penalise the poor and sick. *Journal of Primary Health Care, 6*(1), 4-5.

Norris, P., Tordoff, J., McIntosh, B., Laxman, K., Chang, S. Y., & Te Karu, L. (2016). Impact of prescription charges on people living in poverty: A qualitative study. *Research in Social and Administrative Pharmacy, 12*(6), 893-902.

Our Vision for Change. (2017). Retrieved December 5, 2018, from http://www.huttvalleydhb.org.nz/about-us/vision-mission-values/our-vision-for-change-2017-2027/hvdhb-our-vision-for-change-summary.pdf

Reid, P., Paine, S., Curtis, E., Jones, R., Anderson, A., Willing, E., & Harwood, M. (2017). Achieving health equity in aotearoa: Strengthening responsiveness to māori in health research. *The New Zealand Medical Journal, 130*(1465), 96-103.

Robson, B., Purdie, G., Cram, F., & Simmonds, S. (2007). Age standardisation - an indigenous standard? *Emerging Themes in Epidemiology*, 4, 3. 1742-7622-4-3 [pii]

Robson, B., & Harris, R. (2007). *Hauora: Maori standards of health IV. A study of the years 2000-2005* (4th ed.). Wellington, New Zealand: Te Rōpu Rangahau Hauora a Eru Pomare.

Seneviratne, S., Campbell, I., Scott, N., Kuper-Hommel, M., Round, G., & Lawrenson, R. (2014). Ethnic differences in timely adjuvant chemotherapy and radiation therapy for breast cancer in New Zealand: A cohort study. *BMC Cancer, 14*(1), 839.

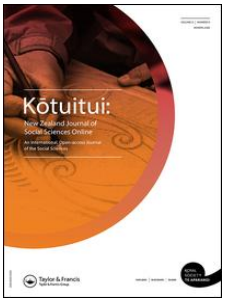
Tatau kahukura: Māori health chart book 2015 (2015). (3rd ed.). Wellington, New Zealand: Ministry of Health. Retrieved from https://www.health.govt.nz/publication/tatau-kahukura-maori-health-chart-book-2015-3rd-edition

Te Karu, L., Bryant, L., Harwood, M., & Arroll, B. (2018). Achieving health equity in Aotearoa New Zealand: The contribution of medicines optimisation. *Journal of Primary Health Care, 10*(1), 11-15.

Trendly (Beta) Promoting High Performance in Health. Retrieved December 5, 2018, from http://www.trendly.co.nz/Home/Performance

Williams, D. R., & Mohammed, S. A. (2013). Racism and health I: Pathways and scientific evidence. *American Behavioral Scientist, 57*(8), 1152-1173.

Wyatt, R., Laderman, M., Botwinick, L., Mate, K., & Whittington, J. (2016). *Achieving health equity: A guide for health care organizations;IHI white paper.* Cambridge, Massachusetts: Institute for Healthcare Improvement. Retrieved from http://www.ihi.org/resources/Pages/IHIWhitePapers/Achieving-Health-Equity.aspx



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RESEARCH ARTICLE

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Māori and Pasifika leaders' experiences of government health advisory groups in New Zealand

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ABSTRACT

Māori and Pasifika populations in New Zealand experience poorer health outcomes than other New Zealanders. These inequalities are a deeply entrenched injustice. This qualitative study explores the experiences of six Māori and Pasifika leaders on health policy-making advisory committees. All had extensive experience in the health system. They were recruited, provided semi-structured interviews, the data coded, and a thematic analysis undertaken. Our findings show that inequalities in the health system are reproduced in advisory committees. Participants noted their knowledge and interests were devalued and they experienced racism and tokenistic engagement. Some indicated it took considerable effort to establish credibility, be heard, have impact, and navigate advisory meetings, but even then their inputs were marginalised. Health policy advisory committees need deeper engagement and more genuine recognition of Māori and Pasifika knowledge. Māori and Pasifika leaders have constructive solutions for eliminating health inequities that could benefit all New Zealanders.

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KEYWORDS
New Zealand; health policy; Māori; Pasifika; racism

Introduction

Aotearoa New Zealand has a long-term population health trajectory that is characterised by deep seated health inequities. Māori (indigenous) and Pasifika (people with genealogical connections to Pacific Island) populations in New Zealand carry the highest burden of disease (Robson and Harris 2007; Marriott and Sim 2014) while the majority, Pākehā (settler peoples) enjoy relatively good health (Moewaka Barnes et al. 2014). Historically these differences arise from colonial policies and practices (Ballara 1986; Walker 1990; Spoonley et al. 2004) that stripped Māori people of their rights, property, infrastructures, institutions and sovereignty (Smith 2012). Likewise, Pasifika peoples have been consistently marginalised by the colonial regime since their arrivals via immigration began in the 1950s (Anae et al. 2015).

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In a contemporary context some of these inequities are the result of uneven access to the determinants of health, while others are impacted by lifestyles that reflect the intergenerational impact of colonisation (Theodore et al. 2015). Starfield (2011) argued that some of this inequity is generated through the administration of the health system; through systems, processes and policies. This paper is directed toward illuminating how inequality is played out in health policy development through advisory groups which, ironically, were established to address inequality.

The number of health advisory groups is often fluid changing with each set of health reforms and new governments. Generally there are some high level semi-permanent committees which people are appointed for a set term connected to central government or district health boards (DHB). There are also more short-term committees called together to develop a particular health policy or strategy. Generally there is usually one or sometimes two Māori and/or Pasifika committee members unless it is an ethnic specific advisory board.

Under *te Tiriti o Waitangi*, the founding treaty of the colonial state of Aotearoa New Zealand, Māori were promised the protection of their health as a taonga (treasure) (Buetow and Coster 2001). The United Nations (2007) *Declaration on the Rights of Indigenous People* and the *Convention on the Elimination of All Forms of Racial Discrimination* (UN 1966) also offers protection in relation to the right to health. Similarly, the *New Zealand Public Health and Disability Act 2000* requires the health sector to work towards eliminating health inequities. Reinforcing this a report by Treasury (2004) concluded that Crown Ministers needed to place the highest priority on initiatives most likely to improve outcomes for Māori and Pasifika populations. They maintained particularly in the long-term, policies would be more successful if they were designed, developed and implemented by Māori and Pasifika peoples.

Public policy provides pathways for government to enact and pursue a political agenda via diverse mechanisms for rationalising and distributing public resources. The prioritisation and framing of policy is inherently political, with such arrangements precluding some options while privileging others (Borell et al. 2009). Shore and Wright (1997, p. 8) argued the ' … political nature of policy is disguised by the neutral, legal-rational idioms in which they are portrayed'. Fischer (1995) maintained policy-makers wield considerable power, since they determine whose values and beliefs underpin the work, the solutions generated, and specific goals. In various ways, the use of advisory or reference groups to inform policy development can moderate, or even shape, the form and application of policy. However, as our study will show such influence is far from assured.

Came (2014) has identified five forms of racism within health policy making. The first is 'the tyranny of the majority'–how 'democratic' decisions are made and who makes then in relation to setting the policy agenda in Aotearoa. A second strand of racism arises from the privileging of biomedical Western evidence over Indigenous knowledge. Moewaka Barnes (2009) asserts that government institutions (including science as an epistemological practice) are not culturally neutral in their appraisal of evidence in the formation of policy. The third influence is the variable cultural and political values and competencies of government officials writing and reviewing policy. The fourth problem is the consultation process pursued during the development of policy, where the wrong questions are often asked of the wrong people in the wrong timeframes. Finally the fifth form of racism is evident within the organisational sign-off process which is frequently political risk-

averse and works to mask, or eliminate, Māori and Pasifika content. Implicit across these sites is the marginalising of Māori and Pasifika voices through health advisory groups.

The authors for this paper are passionate about health equity and are activist scholars; two have Māori whakapapa (genealogy) and two are Pākehā. This paper addresses a gap in the literature relating to the experiences of Māori and Pasifika leaders within government health policy advisory groups. It seeks to explore to how racism manifests in health advisory groups? Qualitative data was collected through key informant interviews with Māori and Pasifika health leaders who have extensive track records within government policy advisory groups. The study suggests more work needs to be done to make advisory groups less tokenistic and more culturally and politically responsive to Māori and Pasifika participants so that their contributions can be both incorporated into policy in a mana enhancing way.

Method

Participants were secured through purposive sampling within the professional networks of the authors. Key informant interviews were undertaken from November 2016 to February 2017. Six Māori and Pasifika public health leaders, with over a 100 years of collective experience in public health, were interviewed. Their contributions drew on their experience spanned several different governments. Rangi, Samoa and Erina had dual Māori and Pasifika whakapapa (genealogy), Nikora and Leona were Māori, and Masina was Pasifika. There was a mixture of genders involved and participants were in their 40s through to their 60s. Note pseudonyms are used in this paper.

The participants had been in a multiplicity of Ministry of Health and district health board advisory and steering groups. Some had been part of such groups for 20 plus years, others around 10 years. Sometimes they were the only Māori or Pasifika members of the group, other times, 20% of the membership, sometimes 50%. Some participants had been on dedicated Māori or Pasifika policy advisory bodies.

The interviews were conducted either face-to-face or by telephone and were carried out in an hour-long, open-ended format. Participants were asked about their involvement in advisory groups and particularly around issues relating to Māori and Pasifika representation in advisory groups, cultural safety, influence on policy, use of equity tools, evidence and racism.

Audio-recorded data was examined using Braun and Clarke's (2006) steps of inductive thematic analysis as a way of categorising the key patterns in the broader discourse. Two authors independently familiarised themselves with the interviews then generated and populated codes. The codes were used to group data excerpts to common themes and track connections among themes. Discursive analysis of pattern and variation in the thematic data were used to define and name themes and to guide the descriptions that follow.

Ethics approval for the study was obtained from the Auckland University of Technology Ethics Committee (No. 16/377) and funding was obtained through the Auckland University of Technology School of Public Health and Psychosocial Health.

Results

The broad themes from the interviews were (i) navigating the room; (ii) the battle of evidence; (iii) working with government officials; (iv) suspicions of tokenism, and (v) witnessing and experiencing racism.

Navigating the room

All participants acknowledged the strategic importance of advisory group work. However, despite some participants being decades into advisory roles, they recognised such work was frequently difficult and frustrating. When starting out in government advisory groups, some leaders recalled feeling daunted and a little unsafe in being a solitary or minority voice. With experience came more confidence and some informants reported becoming more vocal.

Several of the female leaders used the opportunity of whanaungatanga (actively building relationships) at the beginning of a meeting, to table their cultural, clinical, and professional credentials. They believed this improved their chances of being taken seriously. Masina explains;

> I do speak up about my experience because I don't want them to think I've just been plucked in as a brown girl or woman.

In preparing for meetings, participants would identify who was in the room, and then focus on the material and context, while also attending to the mundane details of negotiating for accurate minutes. Masina explains you are 'always looking for who is the driver here? How can we get shift?' She noted the policy language frequently changes so that sometimes for example, the *Treaty of Waitangi* is a significant consideration in the work, while at other times it is absent or neglected.

The environment in the room was not always experienced as supportive. Several participants noted their contributions were often not recorded in minutes. Masina stated:

> When I say something, I don't know if it's me and the way that I speak or my accent or something. I look around the room and often people … have this kind of stunned mullet look. Like, what is she going on about?

A number of informants noted they 'naturally sought strength and solidarity from other minorities'. Practically this meant Māori and Pasifika members of a committee would co-operate within meetings. Sometimes this collectivism was negotiated prior to meeting, at other times it was more ad hoc. Pasifika leaders were happy to stand in solidarity with Māori, but as Samoa confirmed, they deferred to Māori recognising that Pasifika peoples were not tangata whenua (indigenous to New Zealand).

Some contributors acknowledged that they were sometimes emotionally distressed by the processes and content of meetings. Samoa noted there was lack of respect within some meetings, recalling people talking over her, and arrogance from her peers. At times, Samoa had to resort to putting her hand up and physically standing up to be heard. She had raised concerns about behaviour directly with the chair of a committee. Similarly, after exhausting other means, Nikora made a complaint to highlight disagreement with a process and was prepared to escalate it until heard.

Nikora recognised she felt angry at not being heard. Other participants named these experiences as racism. Nikora encouraged prospective advisory group members to do whatever helps you be 'loud and proud and brown'. Samoa advocated for the 'three c's–courage, credentials and credibility'–as the secret to being heard. She deliberately altered the tone and volume of her voice to be heard more effectively.

Most informants had a clear focus on the kaupapa (mission) of long-term outcomes for Māori and Pasifika communities. In the absence of leadership from government officials, Leona explains

HEALTH SYSTEM COMMITTEE PUBLIC - 3.2 Pro-Equity

> We don't sit and wait to see when the crumbs will come. You know, we're proactive. We're looking at the ways in which we can do things better … We will go directly to the Minister.

Rangi reported that over time he has grown intolerant of the absence of authentic support for Māori health and that as a result he was prepared to use his seniority in order to be heard. He expected high performance from his colleagues and was 'focussed on achieving better health outcomes for our [Māori] people'. He maintained

> You can say whatever you like in a meeting or discussion but if it's not contributing to better outcomes for Māori people, then you know, it's just a pointless conversation.

The battle of evidence

In terms of evidence Nikora maintained government officials '… drew on everything that was Western, epidemiological, published in great big fat journals that the world thinks are wonderful'. Several informants shared her concern about the strong reliance on evidence from the global North, the assumed 'gold standard' and 'best practice' perceived as originating there. Rangi stressed for Māori these western approaches have consistently delivered inequitable outcomes. He warned that 'until our people value Māori intelligence, nobody else will … which means we'll never have a system that achieves health equity'. He linked the devaluing of Māori knowledge to colonisation.

Participants noted Pākehā seemed to assume they had expert knowledge, which was inherently superior to what they the perceived as anecdotal evidence from Māori. Nikora observed Māori academic contributions were routinely questioned more vigorously in terms of the validity of the research compared with other academic work. Nikora explained how this denial of Māori knowledge played out;

> … they would write a whole lot more based on what the Pākehā (white) researchers were saying. And because they probably were not understanding what Māori were saying, they didn't write it down, so it didn't get heard.

Erina was disappointed at the quality of the Māori and Pasifika evidence used in strategies. She often felt the evidence enabled a deficit discourse against Pasifika and Māori. Erina wanted to see research that showed positive understandings of her people and culture highlighted. She noted policy analysts 'did not know about key studies' such as the Pacific Island Families Study and likewise, they seemed unable to complete a comprehensive literature review inclusive of Māori and Pasifika research.

In a practical sense, this meant Erina did not see herself, her aiga (family), or her people in strategy documents. For example, a committee she was on was reviewing some infographics that depicted a (white heterosexual) nuclear family–mother, father and two children. She explains:

> It was myself actually and one of the Māori people who raised the idea that for Pacific people that can be quite different. You can have ten plus people living in the same household. You could have your parents and your other parents who are [actually] an aunty and uncle … they really struggled with that concept and how to fit it into their [Western] framework.

Several participants observed a reluctance to examine the determinants of health disparities in ways that could strengthen the strategies. Leona explained,

> They don't understand where the deficits have come from … where we want to see things at the end and how we want to get there.

Nikora advocated that health policy needs to:

> deal with institutional racism, deal with poverty, deal with all those things that are macro economical … those strategies are fluffing around the edges and keeping people in work. Deal with the big stuff. That will make the difference.

Overall there was a view that the knowledge of policy-makers was biased, incomplete and inadequate to inform the development of policy that could eliminate disparities.

Working with government officials

Erina drew attention to the constant turnover of staff within government agencies, while others observed the high proportion of officials that are new migrants to New Zealand. Rangi reported being in groups with people 'who know absolutely nothing about the topic'. He felt this lack of context and background knowledge was a barrier and disenabling to processes and outcomes.

Rangi further observed that government officials had their own [cultural and political] 'filters and biases that they use to assess and make decisions'. He conceded government officials have to manage 'the politics of a prevailing Minister or Ministers' and that this meant what was developed 'might not be as effective as it could be and can lead to greater inequity'.

Leona maintained some government officials had been subsumed by the 'big bureaucracy of government'. She described them as the 'smiling assassins' to signal their tendency to mimic what they hear. Nikora asserted that often government officials simply didn't understand Māori contributions. Masina echoed these concerns noting

> When you do talk, you almost have to, with everything you say, you have to give them a little bit of a picture.

The scarcity of Māori policy-makers was viewed as a problem by several contributors who felt more Māori policy analysts needed to be trained. Rangi highlighted how this was compounded by the wider absence of effective Māori leadership in influential leadership positions within the sector. Leona recognised there were allies within government agencies with good intentions. These allies were sometimes Māori.

Several participants reflected on the importance of who was invited to meetings. Masina noted that if senior government officials were not at the table, it could undermine a process and diminish its mana (prestige). Leona noted:

> you know when the Chief Executive Officer is at the table that decisions can be made. You really need the top two or three tiers, not fourth and fifth tier management from Crown [government] agencies.

In a strategic sense Leona noted there is power in the possibilities of the current Waitangi Tribunal settlement and reconciliation process. Through this process iwi (tribes) can take the government to a permanent commission of enquiry to investigate historic and contemporary breaches of te Tiriti. The current health-related claims (Isaac 2016) represent a unique moment to strengthen the position of Māori as Treaty partners rather than end-users of health services.

Suspicions of tokenism

For Samoa, good policy building requires authentic engagement and functional relationships, yet this was not her experience of being involved in advisory groups. Erina was concerned that at times the advisory committee was there to create an impression of inclusivity rather than have substantive input into policy. She explains

> … they just brought it to us and want us to say, yeah that's excellent, do it, kind of thing rather than, yeah, working with us from the start, what are some good ideas.

Erina perceived the engagement of kaumātua as only ceremonial, since after they opened the meeting they then stepped back. A kaumātua is a respected elder with particular cultural expertise. They contribute to important hui (gatherings), sometimes work with organisations and advisory groups. Often they lead tikanga (cultural protocols and customs).

Nikora observed the kaumātua:

> … was always there which was always nice but he was there more just to make the day right [tika], than he was to make sure that there was a stronger Māori voice … It was a bit token … If he is just there to bless the kai [food] I see that as racism.

She welcomed deeper engagement with tikanga and suggested advisory groups could meet at marae (Māori meeting places) and that participants could bring whānau tautoko (family support) to the meetings.

Witnessing and experiencing racism

Most participants disclosed witnessing and experiencing behaviour consistent with racism–that is patterns and practices of disadvantage and or marginalisation. Some informants named it 'covert', 'sophisticated' or 'institutional' racism. Leona observed

> The politeness is very, very overt. Because it's so sophisticated and people get bloody hoodwinked on that, and our own do.

Specific examples shared included a health equity champion that didn't want anything to do with Māori health, and a proposed breast screening programme that was going to target Māori women through a mosque, even though Māori make up a very small percentage of people attending mosques.

Leona raised serious concerns about the credibility of some DHB advisory committees. She has witnessed their failure to follow correct procurement processes and queried whether DHBs, that consistently run at deficit, can credibly oversee contracting and funding processes with others. She shared the example of health funding that had been retendered as a part of a sector-wide review. An analyses of disease burden and ability to access community was carried out and contracts were awarded through a competitive process. Then the DHB's own provider was given additional funding without having to pass through the same scrutiny.

Discussion

We found very little literature on the use or effectiveness of indigenous or minority representation on policy development advisory committees in the international setting. It is

not clear whether such mechanisms are used elsewhere although there is some evidence of efforts to consult in relation to age and gender. It appears that Aotearoa presents an unusual degree of interest and commitment to such approaches but even here there is little in the way of academic study of the implications of this orientation. The authors maintain Māori involvement is critical for the government to fulfil their te Tiriti o Waitangi obligations and prudent with Pasifika to strengthen the cultural relevance of policy.

Māori and Pasifika health leaders involved in such work interviewed for this study reported variable success navigating Crown government advisory groups and influencing health policy and funding decisions. Accounts of processes and activities of advisory groups suggest that as a setting they can be uncomfortable and emotionally distressing. To be effective and to be heard in such groups required participants to be forthright, resourceful and tenacious. There may be merit in a dual approach having ethnic specific advisory groups, as well as integrated advisory groups representing all stakeholders. We found racism was often normalised within policy processes. Further, government Crown officials, as hosts of advisory groups, could take greater responsibility to embrace more culturally inclusive processes–from how meetings are chaired through to what gets recorded. The onus should not fall exclusively on Māori and Pasifika leaders to prepare for these cultural exchanges.

The unrealised opportunity of developing and improving health policy through the advisory group process could be part of a deeper, and ongoing, strategic engagement between Māori and Pasifika communities and the government. The contributions of kaumātua through appropriate application of tikanga can be positive, but some of the participants experienced it as tokenistic and a barrier to authentic and respectful sharing of their expertise and mātauranga (knowledge). Establishing trust, which is critical to constructive engagement, requires mutual respect and is enriched by a shared vision. Māori as Treaty partners should be able to expect high levels of cultural competencies from government officials and staff recruitment should target these competencies, or existing staff supported to develop them.

The leaders reported Māori and Pasifika knowledge and expertise was frequently ignored, debated, contested or perceived as unworthy or invalid. It is unclear whether this blockage arises from unconscious bias (Blank et al. 2016), and the extent to which it is a reflection of inter-personal, societal or institutional racism (Moewaka Barnes et al. 2013). What is clear is this neglect of grounded knowledge is in direct contrast to the rhetoric of government policy documents that affirm the importance of Māori and Pasifika led-solutions and expertise.

This study highlights the determination and commitment of Māori and Pasifika leaders to remain focused on health outcomes and strategically engaged with the government. Yet more work needs to be done before Māori and Pasifika realities are no longer marginal in the context of health policy. Western paradigms continue to prevail. Many participants shared their dissatisfaction with the policy documents they had contributed to. Too often agreements reached in the working groups change. The post-committee (political) organisational sign-off, can shift the framing and orientation of policy and undermine gains negotiated.

As well as cultural competencies, government officials and agencies need to be equipped with Treaty and intercultural competencies that facilitate partnership approaches rather than conventional stakeholder relations. This requires power to be shared (Ramsden 2002) in terms of decision-making, prioritisation, framing and shaping of meaning (Lukes 2005).

It would be useful for government officials to engage in the rich literatures of cultural safety, cultural competencies and anti-racism praxis so that they are prepared for this.

When committees and advisory groups engage with Māori and Pasifika leaders there is a responsibility to act on the advice provided. These leaders are a valuable resource whose time and skills could be used elsewhere to support their communities. The leaders interviewed had mana and agency; they were knowledgeable experts in their field, with clinical, cultural and community expertise. Inviting these leaders to engage in policy making is a good first step, however the opportunity to include this expertise to address Treaty obligations and inequalities was clearly missed.

Conclusion

Māori and Pasifika leaders are committed to contributing and developing health policy that works for Māori and Pasifika communities. Yet, the leaders had mixed experiences on advisory groups and observed a systemic undervaluing of Māori and Pasifika intelligence. They sought authentic relationships and respectful (rigorous) academic exchange in a context where Māori and Pasifika experiences were not marginalised by western mono-cultural norms. From this study it seems more could be done by government officials and agencies to ensure Māori and Pasifika leaders are respected so that they can fully engage in government advisory groups. Participants in advisory groups should not be witnessing or experiencing racism or unconscious bias from colleagues. To address health inequities it is critical that health policy incorporates solutions from Māori and Pasifika leaders, in order to deliver health outcomes for these communities that at this time carry the predominate burden of disease. Cultural and political competencies of government officials and those leaders that sit on health advisory groups need to be strengthened.

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References

Anae M, Iuli L, Burgoyne L. 2015. Polynesian panthers: Pacific protest and affirmative action in Aotearoa New Zealand 1971–1981. Wellington: Huia Publishers.

Ballara A. 1986. Proud to be white? A survey of Pakeha prejudice in New Zealand. Auckland: Heinemann.

Blank A, Houkamau C, Kingi H. 2016. Unconscious bias and education: A comparative study of Māori and African American students. Auckland: Oranui Diversity Leadership.

Borell B, Gregory A, McCreanor T, Jensen V, Moewaka-Barnes H. 2009. "It's hard at the top but it's a whole lot easier than being at the bottom": the role of privilege in understanding disparities in Aotearoa/New Zealand. Race/Ethnicity. 3(1):29–50. doi:10.1353/rac.0.0027.

Braun V, Clarke V. 2006. Using thematic analysis in psychology. Qualitative Research in Psychology. 3(2):77–101.

Buetow S, Coster G. 2001. Looking forward to health needs assessment: a new perspective on need. New Zealand Medical Journal. 114:92–94.

Came H. 2014. Sites of institutional racism in public health policy making in New Zealand. Social Science and Medicine. 106:214–220. doi:10.1016/j.socscimed.2014.01.055.

Fischer F. 1995. Evaluating public policy. Chicago (IL): Nelson-Hall.

Isaac W. 2016. Memorandum – directions of the chairperson commencing a kaupapa inquiry into health services and outcomes WAI 2575, #2.5.1. Wellington: Waitangi Tribunal.

Lukes S. 2005. Power: a radical view. London: Palgrave Macmillan.

Marriott L, Sim D. 2014. Indicators of inequality for Māori and Pacific people [Working paper 09/2014]. Wellington: Victoria University.

Moewaka Barnes A, Taiapa K, Borell B, McCreanor T. 2013. Māori experiences and responses to racism in Aotearoa New Zealand. Mai Journal. 2(2):63–67.

Moewaka Barnes H. 2009. The evaluation hikoi: a Maori overview of programme evaluation. Auckland: Te Ropu Whariki.

Moewaka Barnes H, Borell B, McCreanor T. 2014. Theorising the structural dynamic of ethnic privilege in Aotearoa: unpacking "this breeze at my back". International Journal of Critical Indigenous Scholarship. 7(1):1–14.

Ramsden I. 2002. Cultural safety and nursing education in Aotearoa and Te Waipounamu [doctoral dissertation]. Palmerston North: Massey University.

Robson B, Harris R, editors. 2007. Hauora: Māori standards of health IV. A study of the years 2000–2005. Wellington: Te Rōpū Rangahau Hauora a Eru Pōmare, University of Otago.

Shore C, Wright S. 1997. Anthropology of policy: critical perspective on governance and power. London: Routledge.

Smith L. 2012. Decolonising methodologies: research and indigenous peoples. 2nd ed. London: Zed Books.

Spoonley P, Macpherson C, Pearson D, editors. 2004. Tangata tangata: the changing ethnic contours of New Zealand. Victoria: Thomson Dunmore Press.

Starfield B. 2011. The hidden inequity in healthcare. International Journal for Equity in Health. 10(15):1–3. doi:10.1186/1475-9276-10-15.

Theodore R, McLean R, TeMorenga L. 2015. Challenges to addressing obesity for Māori in Aotearoa/New Zealand. Australian & New Zealand Journal of Public Health. 39(6):509–512. doi:10.1111/1753-6405.12418.

Treasury. 2004. Reducing Maori and Pacific inequalities. Wellington: Author.

UN. 1966. International convention on the elimination of all forms of racial discrimination. New York (NY): Author.

UN. 2007. Declaration on the rights of indigenous peoples. New York (NY): Author.

Walker R. 1990. Ka whawhai tonu mātou: struggle without end. Auckland: Penguin Books.

Capital & Coast District Health Board ŪPOKO KI TE URU HAUORA	**HSC DISCUSSION PAPER**
	Date: 3 March 2019

Author	Peter Guthrie, Manager Planning and Performance, SIP Jenny Langton, Principal Advisor SIP Wikke Bargh-Koopmans, Senior Advisor SIP
Endorsed By	Rachel Haggerty, Director Strategy Innovation and Performance CCDHB
Subject	**ANNUAL BUDGET AND SERVICE PROPOSAL – UPDATE**

RECOMMENDATION

It is **recommended** that the Health System Committee:

(a) **Notes** that the Annual Budget and Service Proposal process is underway;

(b) **Notes** that the Board strategic direction workshop informs this planning process;

(c) **Notes** that the Executive Leadership Team is taking a whole of DHB approach and including the Integrated Care Collaborative, DHB senior leaders and clinical leaders in the prioritisation process;

(d) **Notes** that the first whole of system senior leaders workshop was held on 4 March;

(e) **Notes** that the Maori Partnership Board, Subregional Pacific Advisory Group and Subregional Disability Advisory Group will provide a critical equity lens to the process.

(f) **Notes** that the Committee will receive a detailed presentation at the Committee meeting.

(g) **Provides** feedback and guidance on the key pressures and priority areas.

APPENDICES

1. Budget and Service Proposal Timeline;
2. Proposal Categories .

Health System Plan Outcomes		**Stewardship**	
Wellbeing Strengthen our communities, families and whānau so they can be well		**Quality & Safety** Quality & safety of service delivery	
People Centred Make it easier for people to manage their own health needs		**Service Performance** Report on service performance.	
Equity Support equal health outcomes for all communities		**Health System Performance** Report on health system performance	
Prevention Delay the onset, and reduce the duration and complexity, of long-term health conditions		**Planning Processes and Compliance** Planning processes and compliance with legislation or policy.	**X**
Specialist Services Ensure expert specialist services are available to help improve people's health		**Government Priority** Equity; Child Wellbeing; Mental Health; Primary Care; Water Safety	

1 INTRODUCTION

1.1 Purpose

This paper provides an update on progress with the budget and service proposal assessments for the 2019/20 financial year. The budget and service proposal timeline for 2019/20 is outlined in Appendix One. At the Committee meeting there will be a presentation and discussion on budgeting and prioritisation, the indicative funding expectations and the opportunities and challenges for CCDHB in meeting Government expectations.

1.2 Background

The Executive Leadership Team (ELT) presented an outline of our key strategic priorities and initiatives at the Board workshop in January, including:

- Minister of Health's Letter of Expectations
- Equity as priority
- Living within our means
- Workforce
- Hospital specialist services
- Are we doing the right things as a regional tertiary provider?
- More and better care in the community

The Board endorsed the general direction presented by staff, including:

- Equity as an underpinning philosophy;
- A whole of system investment approach with a focus on investment in primary and community care to improve health outcomes of the population and sustainability of the DHB;
- Understanding the secondary/tertiary strategy that supports improved health outcomes of the population and sustainability of the DHB; and
- Investment designed to meet health need, be fiscally responsible but not solely driven by deficit management.

Based on the key strategic priorities and initiatives and outcomes from the strategic workshop, priorities have been worked up as service proposals for 2019/20.

2 SERVICE PROPOSALS

More than 80 service proposals were submitted at the end of February from across the health system. These submissions reflect the pressures on provider organisations, priorities for our communities, Government priorities and implementing our Health System Plan 2030

The service proposals are grouped in four categories:

- **Mothers, Babies, Children & Young People** (Mothers, Mothers & Babies, Babies and Young People)
- **Complex Care** (Long-Term Conditions, Health of Older People and Palliative Care)
- **Mental Health, Addictions and Wellbeing** (Community & Primary Mental Health, Specialist mental Health and Alcohol & Drugs)
- **Urgent and Planned Care** (Meeting the urgent and planned health care needs of our communities)
- **Specialist Services** (Specialist and tertiary service development and demand)

An overview of the service proposals and categories can be found in Appendix two.

3 SENIOR LEADERS WORKSHOP

The senior leaders' workshop included senior members across CCDHB as well as members from the Integrated Care Collaborative (ICC). CCDHB priorities, including the Health System Plan, localities approach, community health networks, and regional tertiary service development were highlighted and informed subsequent discussion.

A set of decision making criteria were presented and discussed. These criteria will be used to assess the service proposals:

- Safety & Quality - Ensures an agreed standard of safety and quality
- Equity & Better Outcomes – Improves equity in access and outcome and transforms service delivery by reducing avoidable demand, implementing sustainable models of care or moving care to safe community settings
- Sustainability – improves provider performance

Based on these decision making criteria, a set of questions were presented to be considered for each of the service proposals:

1. Are we clear about the problem we are trying to solve?
2. Do we know who will benefit from the solution?
3. Is it the best place in the life, or disease course, to intervene?
4. Is it the best solution for the person/family?
5. Is this the best place to provide this care?
6. Is this the right mix of workforce?
7. Is technology being considered effectively?
8. What would happen if we didn't do it?

The workshop was well attended. The discussions across the four categories highlighted a set of themes, including:

- Equity as a priority;
- Settings of care;
- Integrated services across the system;
- Sustainability, including workforce pressures.

4 NEXT STEPS

A comprehensive process of engagement with clinical leaders and senior managers to refine proposals is underway. The HSC will play a critical role in the refinement process ahead of endorsing the final service proposals for 2019/20.

Key points in this process to note are:

- Two additional senior leaders workshops, including ICC are being held in March and May to discuss the service proposal;
- Engagement with Māori Partnership Board, Subregional Pacific Advisory Group and Subregional Disability Advisory Group to review the focus on equity.
- The HSC will be able to shape and influence this process through feedback on the update paper at the May HSC meeting;
- The HSC will receive a final paper at its June meeting for review and endorsement to the Board;
- Advice on service proposals for investment in 2019/20 will be provided to the June Board meeting for approval.

Appendix One: Budget and Service Proposal Timeline

Activity	**Timeline/Date**
ELT Workshop	*14 November 2018*
Senior Leaders Workshop	*27 November 2018*
Provide Process and Timeline to ELT and Ops Managers	*19 December 2018*
Board Workshop on Priorities and Investment Opportunities	*31 January 2019*
Service Proposals completed	*28 February 2019*
Budget Drafts Submitted (opex and capex) to Finance	*1 March 2019*
Senior Leaders Workshop, including ICC: considering Service Proposals and priorities	*4 March 2019*
Health System Committee Review	13 March 2019
ELT considers Service Proposals and Budget consideration	1 - 30 March 2019
Senior Leaders Workshop, including ICC	25 March 2019
Maori Partnership Board, SubRegional Pacific Advisory Group and Subregional Disability Advisory Group	15 March – 30 April 2019
Directorates update Service Proposals and Budgets for final sign-off by ELT	1 April – 30 April 2019
Senior Leaders Workshop, including ICC	6 May 2019
Health System Committee Review	15 May 2019
ELT review Budget Submissions including Service Proposals	31 May 2019
ELT approve Capital and Operating Expenditure Investment Submission for Board for 2018/19	11 June 2019
Health System Committee Review & Endorsement to Board	12 June 2019
Board Meeting for Approval	26 June 2019
Ordering/Purchasing to Start after Sign Off by the Board	From July 2019

Health System Committee
Budgeting & Prioritisation

This information provides Directors with an update on the budget and prioritisation process.

The Board Planning Cycle

The Directors will be providing guidance to the Planning Cycle as key points:

- March — Review Draft Annual Plan
- April — Review Budget and Investment Plans
- May — Draft Budgets and Investment Plans
- June — Final Presentation of Commitments

Our purpose

Deliver health services that:

- Promote health and wellbeing
- Prevent onset and development of avoidable illness
- Improve health and wellbeing outcomes
- Support people to live better lives
- Support end of life with dignity

Strengthen our organisation

- Ensure safety and quality of our services
- Create a sustainable and affordable healthcare system
- Deliver on the priorities of government
- Live within our means
- Be a good employer

Our Outcomes

We will:

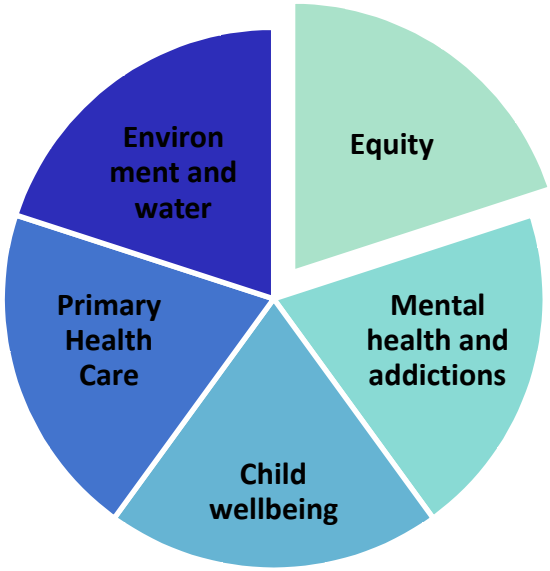
- Strengthen our communities, families and whānau so they can be well
- Make it easier for people to manage their own health needs
- Support equal health outcomes for all communities
- Delay the onset, and reduce the duration and complexity, of long-term health conditions
- Ensure expert specialist services are available to help improve people's health

Making our CCDHB Choices

Safe and quality services

Equity & better outcomes amongst our population

Our sustainable health system



Ministers Priorities

Mothers, Babies, Children & Young People

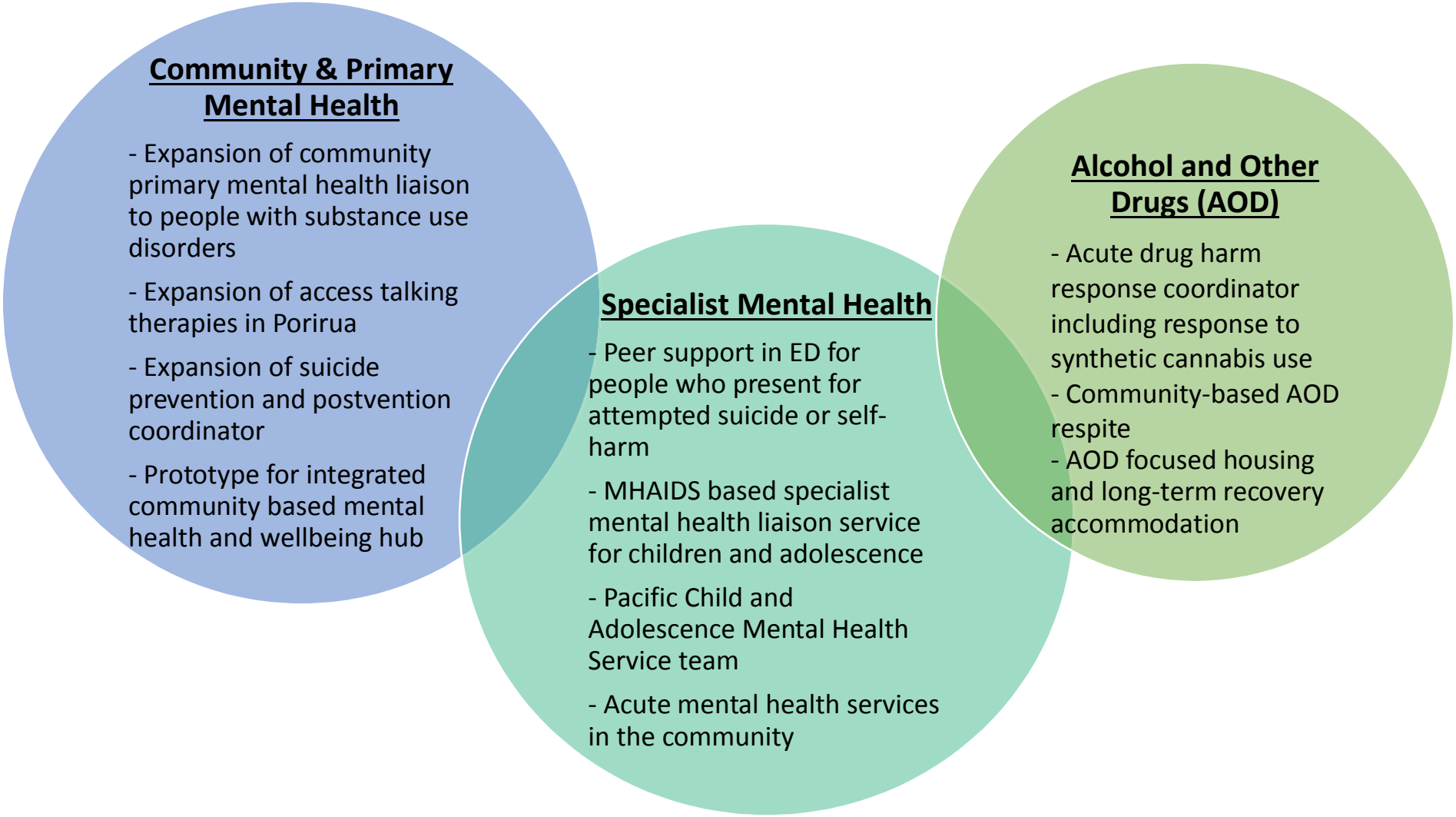
Mothers, Babies & Whānau

- Mama Pepe Tamariki model of care for the first 1000 days
- Community based maternal mental health and wellbeing
- Multi-agency response for family violence
- Vulnerable pregnant women and new babies
- Obstetric Physician for high risk women
- HHS perinatal bereavement service for mothers and whānau
- NICU Service development
- Children's Nursing Leadership workforce

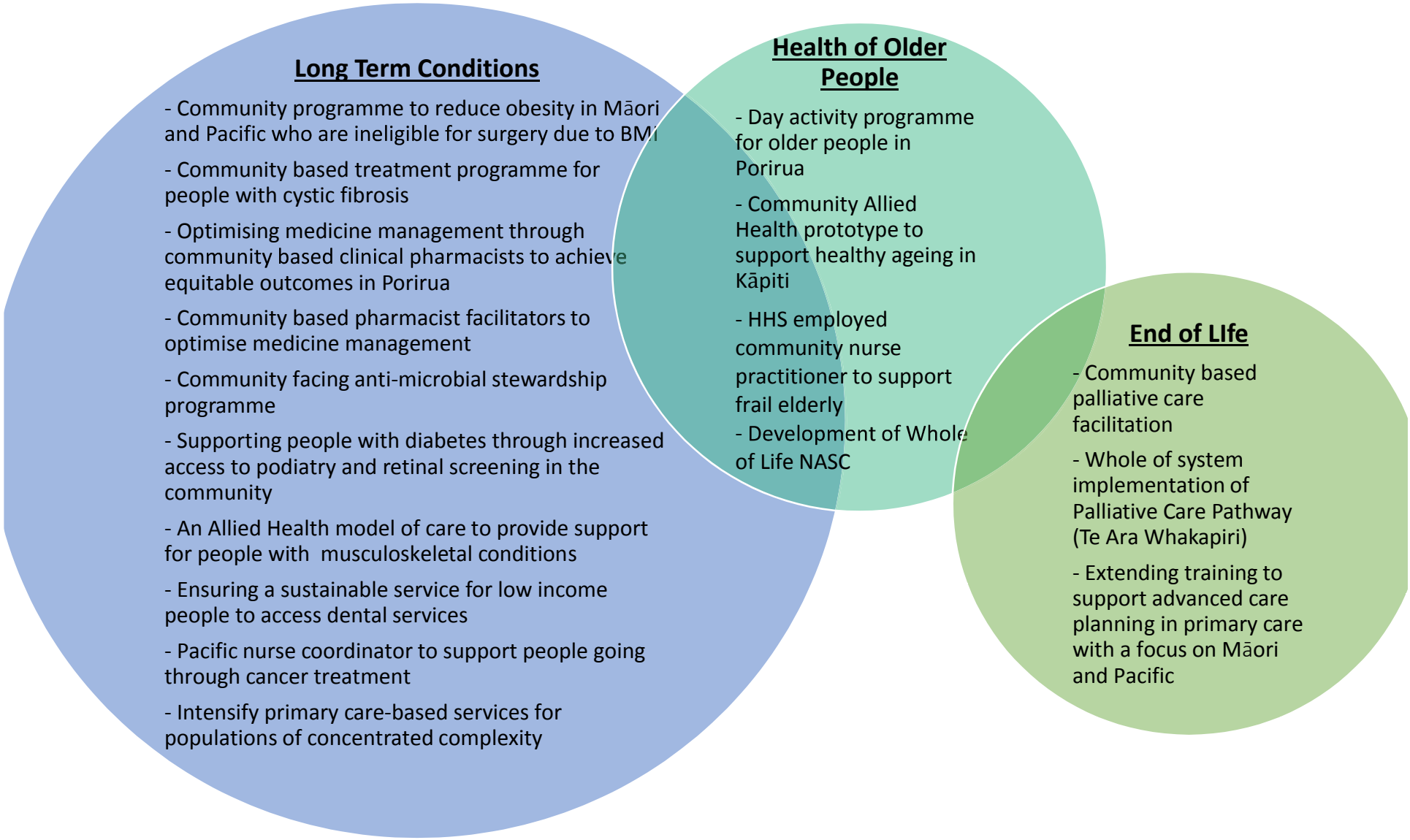
Children &Young People

- Expansion of school based health services - Improving access to gender affirmative health care in primary care
- Dietician Advice and Support for Children with Type I Diabetes

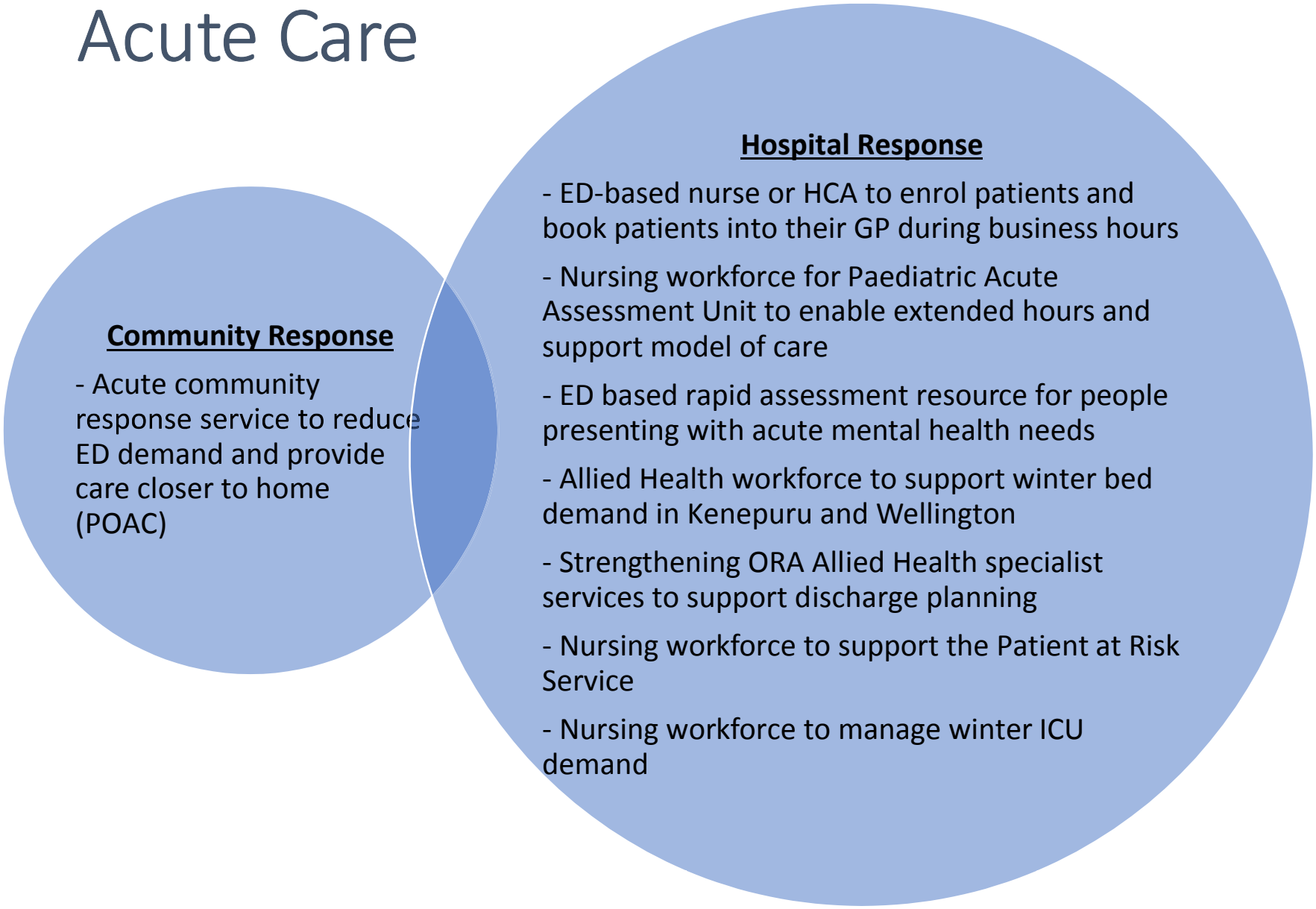
Mental Health, Addictions and Wellbeing



Complex Care



Acute Care


Community Response
- Acute community response service to reduce ED demand and provide care closer to home (POAC)
Hospital Response
- ED-based nurse or HCA to enrol patients and book patients into their GP during business hours
- Nursing workforce for Paediatric Acute Assessment Unit to enable extended hours and support model of care
- ED based rapid assessment resource for people presenting with acute mental health needs
- Allied Health workforce to support winter bed demand in Kenepuru and Wellington
- Strengthening ORA Allied Health specialist services to support discharge planning
- Nursing workforce to support the Patient at Risk Service
- Nursing workforce to manage winter ICU demand

Specialist Services

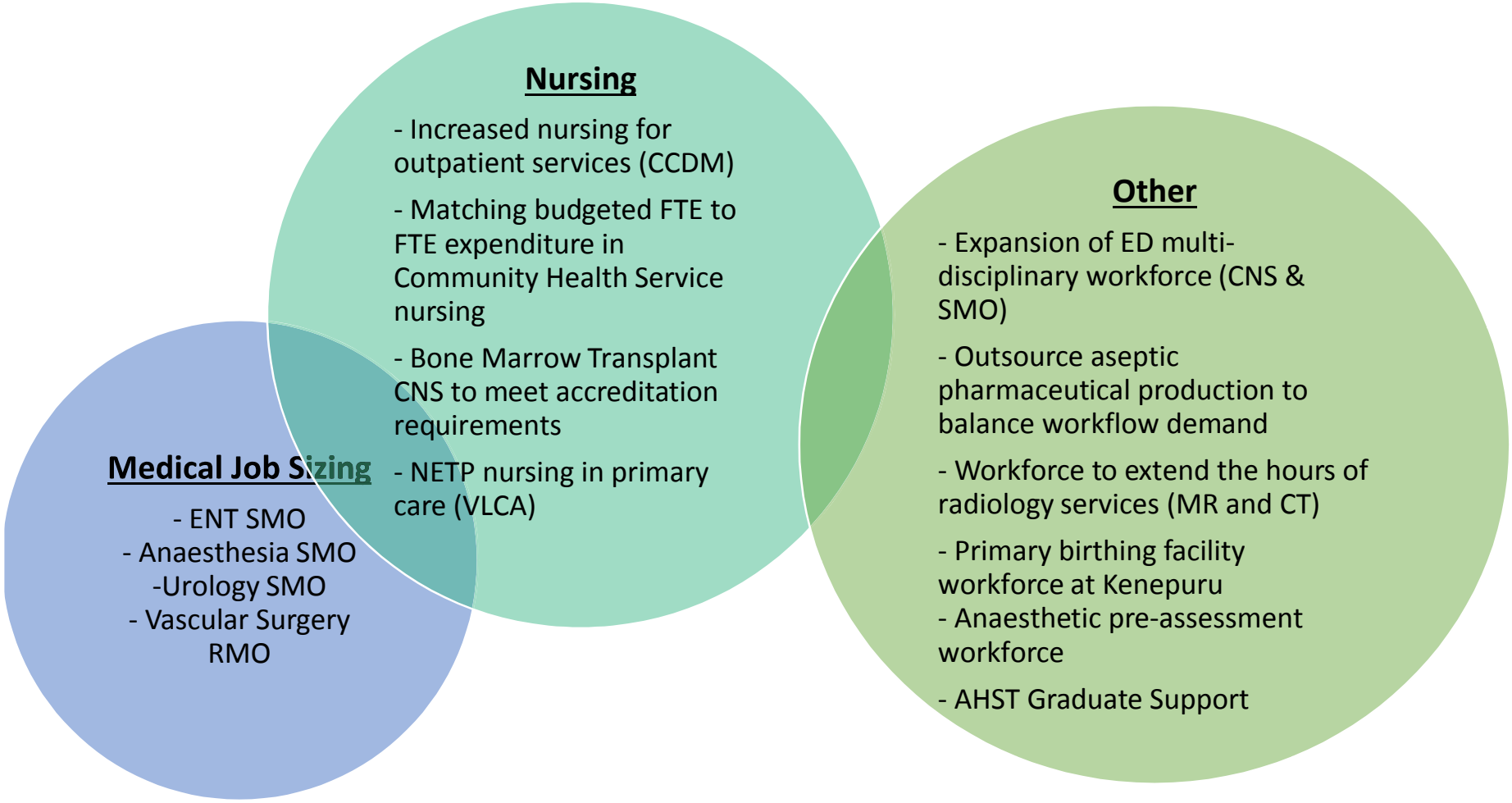
Clinical Response to Demand

- Workforce resource to manage current colonoscopy symptomatic demand
- Set up and trial a service to reduce perioperative morbidity and mortality in high risk surgical patients
- Increase clinic capacity to support in-centre renal dialysis in Hutt Valley DHB
- Extending availability of interventional cardiology services to 7 days a week
- Workforce sustainability for secondary sexual services in the community
- Clinical psychologist support for chronic pain
- Neurophysiologist for wait time management
- Clinical nurse specialist to extended the hours of the nurse-led Vascular Access Team
- Community based ORL/ENT Nurse Practitioner
- Strengthening Specialist Allied Health Services
- Additional palliative care nurse practitioner based in Kenepuru working between hospital and community
- Workforce to continue the development of the Regional Trauma Service at Wellington Regional Hospital
- Nutrition support team service for adult patients

Service Change

- Leadership support for AHST
- Expansion of Sleep Service outpatient clinics to Porirua
- Workforce capacity to resource inpatient and planned ambulatory models of care for cancer
- Workforce to support Genetic Services approach to care
- Expanding the Nurse Practitioner and Registered Nursing workforce in Community Health Networks
- HHS proposed community based follow-ups for glaucoma

Workforce Demand Pressure



Focus Areas

- Equity and outcomes for our communities
- Services in community that prevent demand for hospital services
- Making better use of existing resources to improve equity, outcomes and sustainability
- Quality and safety of current services

PUBLIC

Capital & Coast District Health Board ŪPOKO KI TE URU HAUORA	**HEALTH SYSTEM COMMITTEE DISCUSSION**
	Date: 7 March 2019
Author	Jenny Langton, Principal Advisor, Strategy Innovation and Performance
Endorsed by	Rachel Haggerty, Director, Strategy Innovation and Performance
Subject	**STRATEGY INNOVATION AND PERFORMANCE REPORT JANUARY-FEBRUARY 2019**

RECOMMENDATIONS

It is **recommended** that the Committee:

(a) **Notes** the contents of this update;

(b) **Recommends** to the Board that it notes this update.

1. PURPOSE

This paper updates the Health System Committee on the Strategy Innovation and Performance (SIP) areas of focus during January and February 2019.

SIP has focused effort on initiatives that respond to Board, Organisational and Government priorities such as mental health and addictions, child wellbeing and equity. A key priority has been supporting the development of new service proposals from across the organisations to inform budget decision-making for the 2019/20- Financial year.

2. MENTAL HEALTH AND ADDICTIONS

The Mental Health and Addictions Strategy 2019-2025, "Living Life Well" has now been signed off by the three DHB Boards. We are currently working on an implementation plan (including associated processes, principles and priorities) to roll the strategy out across each locality. This should be ready to present by the end of May 2019.

We are anticipating the Minister of Health's response to the Mental Health Inquiry report, "He Ara Oranga" at the end of March. This is likely to signal what the priority action areas are and potentially whether there will be new investment attached.

2.1 Suicide Prevention and Postvention

The project established to review the health system response to people presenting with suicidal behaviour has completed interviews in CCDHB (Porirua), Hutt Valley and Wairarapa. Initial feedback has been collated into the following themes;

- Emergency Departments are struggling to meet the guidelines for preventing suicide because of increased admissions,
- High staff turnover and lack of training; there is a strong desire to improve current systems for people who present as a result of suicide and/or self-harm behaviour; and
- System challenges and opportunities that can be leveraged in-order to create better outcomes for MH Service users.

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A draft report will be completed by mid-March for consideration and determining the next steps.

2.1.1 Suicide Prevention and Postvention services

The model of delivering suicide prevention and postvention services separately by two different providers has not been working as effectively as we would like. The three sub-regional DHBs have agreed to bring these services together and centrally manage them consistent with the approach taken by other DHBs across the country.

CCDHB is the lead DHB for the agreed Suicide Prevention and Postvention strategic approach working in partnership with HVDHB and WrDHB. The two Suicide Prevention and Postvention co-ordinator FTEs have been established and are based within the CCDHB, Mental Health and Addictions team in SIP. They will provide the prevention and postvention service to CCDHB and HVDHB. Wairarapa DHB will be engaging their own coordinator to deliver these services locally. Both teams will work closely together to provide support and cover when required.

Two Coordinators have been recruited, the first started with the SIP, Mental Health and Addictions team on 4 February and the other will join on 1 May 2019.

The 3DHBs have an interim prevention and postvention plan in place, which will be updated to align with the National Suicide Prevention Strategy when it is finalised and published by the Ministry of Health.

2.2 3DHB Alcohol and other Drug (AOD) Model of Care

This project is reviewing current AOD service configuration, identifying gaps, and/ or duplication of services, and will develop a new AOD pathway and model of care across the 3DHB region. This project is identifying an agreed implementation approach once the new AOD pathway and model of care is developed. The Steering Group involves a number of partners across MHAIDS, funding and planning, NGOs, PHOs and regional public health-representing the 3 DHB's. The first step has been to take a stocktake of existing AOD services across the three DHBs to identify service overlap and gaps in the system. This part of the project is nearly complete and will help us identify opportunities for immediate investment, as well as inform the broader model of care work.

2.3 Lived Experience Advisory Group (LEAG)

LEAG was established in early 2019 following a co-design workshop in December 2018 to provide lived experience expertise into the planning, development and funding of mental health and addiction services across the 3 DHB region. The LEAG consists of 15 members who have lived experience of mental health and/or addiction and/or being a family member of someone with mental health and/or addiction. The group met formally for the first time in January. We are currently working together on a number of processes (e.g. how people are nominated to be involved in pieces of work and how the group nominates the chair - we have an interim chair in the meantime).

LEAG is working on all of the Mental Health and Addictions projects. There is at least one LEAG member on each of our Steering Groups across the MHA work plan. Members are also involved in supporting the DHB to get wider lived experience feedback (e.g. by setting up and facilitating focus groups). This will happen for the AOD Model of Care work as well as the Te Ara Pai review. In the future, LEAG may provide wider input through activity such as peer review documents.

2.4 Te Ara Pai Review

In 2012 an active engagement process with consumers and stakeholders led to the development of Te Ara Pai (Stepping Stones to Wellness) model of care. We have previously advised you that we were

intending to review Te Ara Pai consistent with plans when the model and services were established to evaluate the effectiveness of the model against its intended aims. This review is about to get underway. The findings and recommendations will be used to make appropriate changes to ensure the services provided are appropriate, easily accessible and meet the needs of consumers, and their family and whānau, in particular Māori and Pacific peoples. The review is expected to be completed by June 2019.

3. CHILD AND YOUTH

3.1 Long Acting Reversible Contraceptive (LARC) investment

SIP is finalising the distribution of funding provided via a new Crown Funding Agreement on Contraception Access for free and low cost access to LARCs from 1 April 2019. This additional funding will provide at least 458 women with free LARC insertions and removals and 2,857 low cost contraception consultations each year.

In New Zealand, more than 40 percent of births are unplanned, but some groups of women experience higher rates of unplanned pregnancies. The highest rates of unplanned pregnancies are in young women (80%), Māori (70%) and Pacific women (60%). There are almost double (57%) the number of births from unplanned pregnancies to women living in NZ Dep quintile 5, compared to 29% for women living in quintiles 1-3.

There is a 31 percent increased risk of pre-term birth and a 36 percent increased risk of low birth weight babies, in unplanned pregnancies, which can result in ongoing functional disability, including cerebral palsy, cognitive, motor and language delay. There is also a higher risk of foetal alcohol spectrum disorder and persistently poorer mental health outcomes for mothers.

New Zealand and international data shows that cost is one of the critical factors in contraceptive access. Access to contraception gives autonomy to girls, women and couples to choose the timing of their pregnancies and pursue other priorities, such as education, financial, personal, family or work goals. This improves long term health and wellbeing for women, children and families.

3.2 Gender Affirming Healthcare

In February, SIP facilitated the development of a CCDHB referral pathway to the MoH national high-cost treatment pool for genital reassignment surgery. This will streamline the process for the CCDHB sex and gender diverse community to engage with nationally funded services, and bring CCDHB in line with other DHBs in New Zealand. The second stage of this work is reviewing the availability and access to other gender affirming surgeries (such as mastectomies, hysterectomies and orchidectomies) for the CCDHB population.

The sex and gender diverse community is known to experience a much greater burden of physical and mental ill-health and substance abuse than the general population. Providing clarity around referral pathways and access to gender affirming healthcare is a critical strategy toward delivering on the Health System Plan's vision to eliminate inequitable differences of the health of the sex and gender diverse population.

4. 3DHB DISABILITIES SERVICES

4.1 Community-based deaf wellbeing group

Deaf people who use New Zealand Sign Language (NZL) face multiple barriers to equitable healthcare, stemming from linguistic and educational factors and inaccessible service delivery. Compromised access to social determinants of health mean Deaf people are consistently found to be at a higher risk of and experience higher rates of mental illness then the general population, with one researcher suggesting 50% of Deaf people experience mental illness at some point in their lives, compared to the hearing population of 25%. Mental health services often do not view a Deaf person from a cultural-linguistic lens

meaning the risk for misunderstanding and misdiagnoses are common. Poor provision of New Zealand Sign Language interpreters means many services are inaccessible.

A project is underway to improve the health and wellbeing of the deaf community via developing lasting connections within the community and with community health providers. We expect the development of the community based deaf wellbeing group will lead to:

- Improved cohesion and acceptance of others within the Deaf community
- Utilising and enhancing existing community resources
- Improved relationships between health providers and the Deaf community
- Improved health and wellbeing

4.2 Disability Alerts

The 3DHB Disability Alerts are being reviewed as part of our co-design programme. The disability team are working with a small group of people with disabilities to clarify the purpose of the disability alerts, improve the quality and to make recommendations to improve staff (including clinicians) and patient use of the disability alerts. The review is to be completed by May 2019.

4.3 Accessibility

Accessibility was identified as a priority by consumers at the Forum held in November 2018.
We are planning an Accessibility Audit to identify how accessible our facilities and key information are, and to provide recommendations for improvement during 2019/20. Representation will come from disability groups, Māori and Pacific peoples.

5. COMMUNITY AND COMPLEX CARE

5.1 Improving the rate of Māori enrolment in primary care

More than one in ten (15%) people who identify as Māori in CCDHB are not enrolled with a primary care provider. It is important for people to be able to easily access primary care services as they provide continuity of care throughout the lifecourse. Services range from immunisations for young children, care when you are acutely unwell, long term conditions management support and palliative care in the last days of life. If you are not enrolled in primary care you are more likely to access Accident and Medical services, present to the emergency department or be admitted to hospital.

There are a range of primary care providers within CCDHB including iwi-owned and run practices, union health clinics, youth one-stop-shops, very low cost access practices, and mainstream general practices.

In February, we met with the CCDHB Māori Partnership Board to discuss strategies to improve outcomes for Māori through a focus on the continuity of care offered by enrolment in primary care. The work currently underway with primary care providers to respond to this challenge includes:

- Understanding how people who are not enrolled use ED, inpatient, and A&M services to identify opportunities to put in place processes to facilitate enrolment,
- Working with PHOs to understand un-enrolment practices and contact methods before un-enrolment,
- Implementation of the PHO data ethnicity audit toolkit use in primary care practices,
- Ensuring babies are enrolled at birth using the triple enrolment form,
- And working with Maori community health providers to ensure all service users are enrolled with a primary health care provider.

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5.2 Health of Older People

Home and Community Services

The new service providing home and community support for people over the age of 65 years will start on 1 April 2019. Nurse Maude is joining Access Health Care in providing the service. Each provider will have a 50% split. Transition planning is well underway with both clients and support workers having been allocated to a provider. Nurse Maude have recent experience with setting up a HCSS. They were awarded the contract in Nelson/Marlborough in 2017 and are now providing services along with Access health care in that DHB. Nurse Maude are establishing an office in Porirua and will have satellite offices in Kapiti, Lower Hutt and Newtown. The manager has been appointed and is being supported by a regional manager. Meetings with HVDHB and CCDHB staff are underway to introduce the new provider.

Aged Residential Care

Johnsonvale Rest Home and Hospital is in the process of closing. The NASC is working with the facility, residents and whanau in their move to alternative facilities. On 6 March there is one resident who is yet to find an alternate facility.

Bed Availability

CCDHB has an occupancy rate of 88% for all available beds. The New Zealand total is 87% occupancy. For the central region the figure is 88%. Availability of beds can be influenced, in the short term, by facility closures and new builds. Eldon Lodge closed their dementia unit in 2018 because of low occupancy, Johnsonvale is closing because of low occupancy. The initial flow on effect is that the other facilities with low occupancy will experience a period of high occupancy. This balance will be changed when a new build occurs. Ryman have signalled 120 bed facility in Karori (building has not started and there isn't yet a completion date) and Presbyterian Support are renovating their currently closed facility at Kilmarnock, which will likely have 72 beds. Building is yet to start and time for completion once it has is 12 months.

The DHB can, in times of increased demand and lower bed numbers, reduce the number of people who transfer into the area, use facilities in Hutt Valley and increase the support to people at home temporarily. Dementia Beds within the Wellington region are limited despite the increase of 17 beds at Poneke House in 2018. In the future the Ryman facility in Karori will have 40 dementia beds. Meantime facilities with dementia units are aware of the need to move people out of the unit if they no longer need secure care.

Certification

Almost 60 percent of our aged care facilities have a four year certification which is the longest period a facility is able to be certified. This reflects positively on the standards our facilities maintain.

5.3 Palliative Care

The Palliative Care Steering Group (part of the ICC) has been driving our collaborative interdisciplinary approach to implementing the community-focused Living Well, Dying Well sub-regional strategy. A model of care has been identified and three service proposals put forward for consideration through 2019/20 budget process. The Wellington Hospital Palliative Care Team and The Mary Potter team, are also looking at how to work more closely together. Key to the success of this work will be the successful engagement with primary care providers to support the sector to, in time, take the lead for palliative care for their patients.

Key gaps for palliative care remain:

- In some circumstances people and their whānau/personal support entering the end of life stage are not aware, or identified early enough, and as a result may not be as well prepared for that phase of life as they could have been. People may not understand what it is to be informed and prepared as whanau/personal support.

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- People with palliative care needs may not be aware of what services are available to them or believe they cannot afford to access such services.
- Some primary and specialist service provision is not comprehensive, nor available at all times. In addition, some primary and community services need additional access to specialist support and education to deliver palliative care confidently.
- Co-ordination and integration of services – clinical and social - is variable with duplication or omission of service occurring.
- Inadequate resourcing of palliative and end of life services is also reported.

PUBLIC

Capital & Coast District Health Board ŪPOKO KI TE URU HAUORA	**HSC INFORMATION PAPER**
	Date: 7 March 2019

Authors	Delwyn Hunter, Executive Director Surgery, Women & Children's Carey Virtue, Executive Director Medicine, Cancer & Community
Endorsed by	Julie Patterson, Interim Chief Executive
Subject	**HOSPITAL & HEALTHCARE SERVICES (HHS) BI-MONTHLY PERFORMANCE REPORT**

RECOMMENDATIONS

It is **recommended** that the Committee:

(a) **Notes** the impact on service provision that has resulted from the RMO industrial action and the anticipated effect of the other planned strikes;

(b) **Notes** the work underway to ensure standards of instrument sterility continue to be met;

(c) **Notes** the outsourcing of some pharmaceutical manufacture as a result of machine failure in pharmacy;

(d) **Notes** the work underway with Hutt Valley to develop options for managing dialysis capacity for the region;

(e) **Notes** the preparations being made for the implementation of the National Bowel Screening Programme at CCDHB in March 2020 ;

(f) **Notes** the continued growth of the regional Cardiology service;

(g) **Notes** the higher access rates for Māori and Pacific peoples for cataract surgery.

(h) **Notes** the potential for significant impact on health care delivery with the expansion of genomic medicine;

(i) **Notes** the Key Performance and health target results.

1. INTRODUCTION

1.1 Purpose

The purpose of this paper is to inform the Health System Committee of key activities and priorities being progressed through the Hospital and Healthcare Services of CCDHB.

2. KEY ISSUES / PRIORITIES

2.1 Industrial Action

RDA industrial action – Resident Medical Officers

From December to February inclusive, there have been five 48 hour periods of industrial action by Resident Medical Officers (RMO's) who are members of the Resident Doctors Association (RDA). The last period of industrial action was February 26-28.

Each individual period of industrial action has significant impact on hospital services delivery. There is extensive planning undertaken in the lead up to the strike which takes staff away from normal activities, and there is a reduction of planned surgical activity to reduce the occupancy of the hospital for the strike

period. During the strike period care is provided by a greatly reduced workforce, with increased reliance on our Senior Medical Officer workforce to provide services normally provided by junior medical staff. The immediate post-strike phase is one of recovery and catch up of work where that is possible. It is not possible to catch up on all work that is deferred during the lead up to and during periods of industrial action as the opportunity to undertake the work is lost. This particularly applies to lost operating time, interventional procedures and clinics. We do not have the capacity to undertake additional work, over and above our normal work, to offset the loss in production.

At this stage negotiations between the RDA and DHBs is ongoing and unless settlement is reached, more industrial action is expected.

MERAS industrial action -Midwives

In the absence of achieving settlement of the MERAS collective agreement late last year, further industrial action occurred on 14 February. This industrial action was a complete withdrawal of labour for a twelve hour period which was markedly different from the previous action which consisted of twice daily two hour periods of labour withdrawal over a two week period.

NZNO and MERAS both provide coverage for midwives. Approximately 50% of CCDHB's midwifery staff are members of MERAS which is quite low when compared to other DHB's who have 80-100% of staff covered by MERAS. Consequently CCDHB was in a better position than most DHBs to manage the strike period and was the only DHB that didn't require life preserving services provided by striking staff members. We did however take all reasonable steps to reduce elective activity during the period and were supported by a number of staff who otherwise would not have been working on that day.

At this stage it appears that a settlement is close and we are not expecting any further industrial action.

APEX industrial Action Medical Physicists

CCDHB received notice of intended strike action for Medical Physicists for two periods of seven days from March 12 – March 25 with the expectation that there will be ongoing and continuous action. This national action will affect all six cancer centres in New Zealand.

Medical physicists have responsibilities in areas of diagnosis and treatment. In Radiation Oncology they ensure that cancer patients receiving radiation therapy receive the correct dose of radiation in a safe manner. Physicists ensure that linear accelerators used in the delivery of radiation give the correct dose to millimetre accuracy. This involves regular quality assurance on all treatment devices. Physicists also assist in planning individual patient's treatment and checking that it is delivered correctly.

The nature of the action means that there will be no work at the machines after 4:30 pm or before 8 am for seven days a week. For CCDHB this is the time when the machine maintenance and quality checks occur (taking 3-4 hours at a time) and so this will need to be transferred to the work day resulting in deferral of planned work. Our contingency plans are being developed to ensure there is as little deferred or interrupted patient treatment as possible. Life preserving services have been requested and agreed at this stage but there is a risk that as the action continues there will be less capacity to manage treatment within acceptable timeframes and there will be an impact on service quality activities in order to maintain uninterrupted service to patients.

Mediation occurred on the 4th of March and concluded with no change to the planned industrial action. APEX advised that notices will continue to be rolled out until an offer is made. It is expected that actions will escalate, as time progresses.

PUBLIC

2.2 Specialty Trainees of New Zealand (StoNZ) Multi-Employer Collective Agreement (MECA) Implementation

The StoNZ MECA was ratified in December 2018 and CCDHB has 35 junior doctors that have joined this union. This is a relatively low rate of membership compared to the other tertiary DHBs and possibly relates to the comparative lack of marketing undertaken by SToNZ in our region. The implementation of this MECA is proving to be quite challenging with junior medical staff working on the same specialty roster but having different terms and conditions relating to rostering practices. Implementation requires services to review all run descriptions to ensure the wording aligns with the MECA. Lump-sum payments were made to members on 29 December, and the provisions of the MECA were applied from 21 February with backdating of any entitlements to 10 December (when the MECA came into effect). Setting up Continuing Medical Education (CME) funds will be finalised next month.

2.3 Impact of the Children's Hospital build on the Cancer Centre

With the development of the new children's hospital, the plans include connecting Wellington Regional Hospital and the new children's hospital with a link bridge. This will enter the building through the Cancer ambulatory centre requiring that the day ward, clinic space, and office space be redesigned and moved from the current location.

A significant programme of work is underway to plan and develop options for the cancer day ward and clinic space within the current footprint. This in turn requires that that the offices will need to be relocated elsewhere in the hospital campus but as close as possible to the clinical areas. Plans are being developed to identify options for the new office space, the relocated cancer day ward, reconfiguration of the clinic space and locating clinics during the build.

2.4 TrendCare and Care Capacity Demand Management (CCDM)

The Care Capacity Demand management (CCDM) programme continues apace. A well-functioning partnership framework working in full collaboration with the Unions has contributed to the programme success. TrendCare has been implemented into the 30th area in the organisation this week with plans to extend to a further four areas by August 2019. Implementation across the mental health and forensic units is going according to plan – all eight areas will be implemented by October 2019. Improvement plans are in progress with the two existing mental health areas already integrated into the programme.

As Trendcare users become familiar with the application the accuracy of the inputs is improving thus leading to a better view of patient acuity and staffing requirements across the hospital. The programme team will continue to work with particular areas to ensure Trendcare reflects the most accurate and up-to-date information across all areas. From mid-March there will be a CCDM dashboard integrated with QLIK (the hospital data analytics software) providing programme visibility across the organisation which is generating interest from other DHBs.

FTE calculations are underway with the first report for six areas within the Surgery, Women and Children's directorate currently being finalised. Roster testing is in progress for areas within the Medicine, Cancer and Community directorate.

An overarching escalation plan has been developed as per the terms of settlement of the Nursing and Midwifery MECA. An escalation plan for the emergency department is under development with area specific escalation plans to follow. The variance response management work stream is now focusing on standard operating procedures to support the escalation plans and to link with variance response management. Consideration is being given to the requirements of a variance indicator scoring system.

PUBLIC

The programme has benefited greatly from the CCDM and TrendCare resource appointed through the additional funding from the Ministry of Health and the Accord. These roles have all been appointed to

The total vacancy rate for nurses, health care assistances and midwives at this time is 4.96% (81.45 FTE).

2.5 Sterile Services

Sterile Services process all reusable instruments for operating theatres and wards/outpatient units at CCDHB. Following the recent incident at HBDHB when unsterilized instruments were used, the service undertook an audit of all processed instruments to ensure that they were marked as sterilised and also undertook an audit of the sterilisation processes. No unsterile instruments were identified and all quality processes to ensure instruments are sterile met the expected standards.

The audit did identify two areas where quality improvements could be made. The sterile services unit has restricted access but the design and collocation with theatres gives theatre staff free access to the unit. There is a risk that instruments could be removed from the unit prior to the quality checks having been completed. The mitigation is to restrict access to sterile service staff and planning is underway to implement this. The second issue identified related to the variable knowledge of health professionals within the organisation as to what sterilisation markers they should look for on the packaging to verify instruments have been sterilised. An education package for staff is being developed.

2.6 Pharmacy Manufacturing

Pharmacy Services' Aseptic Production Unit (APU) is responsible for manufacturing (compounding) medicines on site. The unit has two isolators to manufacture these drugs. Most of this work is associated with producing cancer drugs. This was historically outsourced but since bringing this back on site in 2013/14 there has been increasing pressure on the unit including

- Increasing demand for the APU services as a result of increased patient volumes and also the ongoing release from PHARMAC of funding for new and approved chemotherapy agents
- Challenging environmental conditions within the APU in regard to space
- Vacancies and staff turnover
- Staff injuries as a result of work practices
- Inefficiency due to short stability of product
- Failure of the isolator

There are challenges with the condition and capacity of the isolators to manage current demand and in recruiting staff to support in-house compounding. The anticipated release of additional chemotherapy drugs by PHARMAC in 2019 year will result in further increase in demand for production which will be difficult to meet within both current resourcing and existing facility, as the constrained environment and floorplan does not support an efficient compounding process.

In February one of the two isolators broke and remains out of commission while waiting for parts from overseas. Consequently the service will need to outsource work to keep up with demand.

The service is developing a longer term plan to balance the workflow demands, reduce the health and safety risks for staff and allow time for the development of a clear and ongoing understanding of both demand and capacity for this service

2.7 Renal Dialysis Capacity

The satellite unit at Kenepuru will reach capacity in June 2019. The 2012 Business case for the development of the Kenepuru Satellite unit, proposed the development of a second unit in Hutt Valley by

this time. The Renal service continues to look at its Model of Care to ensure home based treatments are in place wherever possible although this is affected by the increasing transplantation rates.

Approximately 40% of the patients served by CCDHB come from either Hutt or Wairarapa domicile. 38 of the current incentre patients at Kenepuru come from the Hutt domicile. Of that population 60% live in the valley between Epuni/Naenae and Taita. Diabetes is the leading cause of end stage renal disease in NZ, and Māori and Pacific have a known higher incidence of diabetes with secondary renal impairment

CCDHB is currently working with HVDHB and Wairarapa DHB on the options for managing dialysis capacity for the region

2.8 Bowel Screening

CCDHB has been developing a business case for the Ministry of Health (MOH) containing the implementation and delivery plan for the National Bowel Screening Programme (NBSP) this is with the MOH for review. Once reviewed approval to proceed will be sought from the CCDHB board and the document will then inform the MOH NBSP business case to Treasury.

The bowel screening implementation project awaits confirmation from the MOH of the March 2020 start date. This timescale depends on the development and implementation of the new National Screening IT Solution (the NSS) by the DHBs using the previous system. Unfortunately confirmation of a start date may not be until late 2019, nevertheless CCDHB will still be expected to commence screening 3-4 months later. It is highly likely the implementation project will need to commence in August 2019 without surety around a Go-live date. A request has been put by CCDHB to the MOH for continuation of implementation funding if delays with the IT system cause the service Go-live date to be later than March 2020.

Between now and August work will continue on colonoscopy production planning and work to understand why the Māori and Pacific population appear to be underserved with regards to Endoscopy procedures. In 2016/17 Māori made up 11.5 percent of the CCDHB population but only 6 percent of all endoscopic procedures; Pacific people made up 7 percent of the CCDHB population, but only 4 percent of the endoscopic procedures. Work is underway to eliminate the colonoscopy waiting list in which Māori are overrepresented in the patient cohort who wait longest. Once bowel screening commences the Bowel screening Equity, Communications and Engagement Working Group are tasked with ensuring that priority populations are able to fully participate and fully realise the benefits of the programme. The benefits of providing bowel screening at Kenepuru Community Hospital include greater access to and promotion of bowel screening in the most socially disadvantaged communities within CCDHB.

2.9 Cardiology

In recent years the Cardiology service provided by CCDHB has faced increasing pressures associated with:

- Growth in local demand driven by an aging population with more complex needs, multiple co-morbidities and the application of new practices
- Changes in the services provided in other DHBs in the region and sub region
- Growth in demand associated with the availability of new technologies
- Ministry of Health treatment thresholds
- Increasing regional demand for tertiary services

There has also been an increase in acute demand for cardiology with 57% of cardiology admissions presenting acutely and resulting in a diagnostic procedure and/or intervention.

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There has been an increase in demand for arranged cardiology procedures from across the region (21%) and via ED (16%). With changes to clinical practice resulting in primary angioplasty rather than thrombolysis adopted as the standard of care for STEMI (Myocardial Infarction) Wellington has become the regional centre for the treatment of STEMI patients for Hutt Valley DHB, Wairarapa DHB, Hawkes Bay and Midcentral DHB and is therefore caring for greater numbers of these patients. This has put particular pressure on the interventional cardiology service. The wards are also experiencing greater demand as the waiting list for elective surgery grows and more patients are breaching the 120 day treatment target. The Transcatheter Aortic Valve Implantation (TAVI) service has experienced a 50% growth in referrals.

The expectation is that the plans to manage the Coronary Angiography waitlist (Section 3.3) will release sufficient capacity to allow the service to accommodate the other service pressures in the short term. However regional planning for Percutaneous Coronary Intervention (PCI) labs has indicated that CCDHB will be required to continue to support Interventional Cardiology growth for at least 5 years before PCI is likely to be available in Hawks Bay or Mid Central DHBs thus alleviating some of the pressure on the CCDHB service.

Data captured regarding access to the service by Acute Coronary Syndrome(ACS) patients who require treatment within 72 hours of diagnosis shows that there is little variance between ethnicities across all of the ACS indicators demonstrating that Māori and Pacific patients have similar access to and treatment within this service.

2.10 Equity – Cataract and Total Hip Replacement procedures

The standardised intervention rate (SIR) for cataract procedure for the 12 month period ending 30 September 2018 is 37.52 per 10,000 population. This compares to a national target intervention rate of 27.00 per 10,000 population. CCDHB's SIR is significantly above the national target. CCDHB was the 7th highest ranked DHB for this intervention.

The SIR for total hip replacement surgery for the same period was 14.11 per 10,000 population. This compares to a national average of 12.81 per 10,000 population. CCDHB's SIR is not significantly different to the national average intervention rate. CCDHB was the 7th highest ranked DHB for this intervention.

Cataract procedures and total hip procedures are two of the more common procedures undertaken by CCDHB for our local population. The table below shows ethnicity as a percentage of the total CCDHB population across all ages and for the population aged over 50 years. By far the majority of cataract and total hip procedures are undertaken on people aged over 50 years. The table also provides the percentage of cataracts and total hip procedures performed by CCDHB by ethnicity.

Cataracts and Total Hip Replacements 2018

Ethnicity	CCDHB Population all ages	CCDHB >50 population	Cataracts	Total Hip Replacements
Asian	11%	8%	7.26%	1.45%
Maori	9%	5%	7.41%	7.25%
Pacific People	7%	4%	9.97%	2.42%
Other	73%	83%	75.36%	88.89%

Maori represent 5% of CCDHB's population aged 50 years or more and received 7.41% of the total number of cataracts performed. Similarly Pacific People comprise 4% of the population and received 9.97 % of cataracts performed. There are a number of recognised risk factors for developing cataracts besides advancing age and these include: hypertension, diabetes, obesity and exposure to ultraviolet radiation (sunlight). It seems likely that the greater health burden experienced by Maori and Pacific People, compared to other populations, is contributing to the need for cataract surgery. If there are access issues

in primary and community care settings, then it is possible that we are still not meeting the needs of these populations despite the current intervention rates.

For total hip replacement surgery the percentage of procedures compared to population breakdown is more closely aligned, with the exception of the Asian population. There is a lower incidence of osteoarthritis in the Asian population and this will be one contributing factor. Based on our SIR CCDHB has good access for hip replacement surgery.

2.11 Genetics

Genomics is fundamental to the future of healthcare in its ability to transform outcomes for patients. Our genome is unique to us all, it contains genes; genetic information needed to make, run and repair us. Sequencing is the technology required to read this genetic information.

Sequencing the first human genome took 13 years at a cost of US $1 billion. Today it can be completed in a day at a cost of US $1.5K and this cost is falling.

This giant leap in technology is resulting in:

1. Our ability to diagnose rare disorders and find the cause of unexplained illnesses (~50% diagnostic rates). Increasingly there are life transforming treatments that not only benefit patient quality of life but also result in substantial lifetime cost savings to healthcare.
2. The identification of subgroups of patients with common disorders i.e. diabetes who will respond better to more effective and cheaper treatments.
3. Better outcomes for cancer patients (including breast cancer, melanoma and lung cancer) where the genetic changes identified in their tumours can lead to the use of targeted personalised therapy resulting in extra years of good quality life for many and the use of cheaper more effective drug treatments. Sequencing can also identify patients who will do better with fewer radiology treatments.
4. Preventative medicine. Improved risk assessments for those with a family history of inherited cancers. Identifying high risk healthy people enables cancer risk reduction through surgical management and chemoprevention.

Genomic medicine is the use of this genomic information as part of clinical care (e.g. to establish a diagnosis or to guide the therapeutic approach) and the application of this technology to health outcomes and policy implications. It is starting to revolutionise healthcare through reduced time to diagnosis, increased diagnostic rate, improved risk assessment, individualised therapeutic choices and informed allocation of resources.

3. KEY PERFORMANCE INDICATORS

3.1 Elective Health Target

Providing access to timely elective services is a priority for the Government. The required volume of elective services to be delivered is set as the elective health target and is 11,208 for the current year. The target is comprised of all elective and some arranged surgery performed for our local population. It includes work undertaken by CCDHB and also work undertaken by other DHBs on our population. The target has been increasing year on year as the Government has continued to

invest in elective procedures. CCDHB has consistently achieved the health target over the last eight or more years.

Currently we are 125 procedures behind a year to date target of 6,504. Up until December we were reporting a small favourable variance to target. The key driver for our adverse position is the industrial action undertaken by the RDA. We have estimated that we have lost approximately 300 elective discharges related to the industrial action. These discharges include both local and IDF patients with a significant proportion being local patients that would contribute to the elective health target.

There is also a financial impact associated with being behind in the elective health target. We have approximately $19m revenue associated with 'additional elective services' (both inpatient and ambulatory) and year to date we estimate that we have over $500k at risk. This may deteriorate further as estimates are dependent on patients having been discharged and the medical record coded.

3.2 Elective Service Patient Flow Indicators (ESPIs)

ESPI 2 relates to waiting times for First Specialist Assessment (FSA) and ESPI 5 relates to access to treatment. Both are measures of timeliness of service provision and to be compliant assessment and treatment need to be provided within 120 days of receipt of referral or decision to treat.

For several years CCDHB has remained ESPI compliant in both measures, being the only DHB that was compliant for the 12 months ending November 2018. CCDHB became noncompliant in both ESPI 2 and 5 in December and we remain non-compliant.

There are multiple drivers to our noncompliant position but one of the key factors does relate to the industrial action taken in December and ongoing. The months of December, January and February are always challenging in terms of ESPI compliance because of the reduced working days which effectively was further reduced by strike action. Four working days per month were lost in January and February as well as time leading up to the strike period where activity was reduced to lower hospital occupancy and time post-strike was also impacted as SMO had been working in the night to cover RMO duties.

The current level of ESPI noncompliance is outlined in the table below. March numbers are forecast only and may change. While we continue to work on regaining ESPI compliance, it is within the context of SMO's feeling tired having performed additional work over a prolonged period of time to cover RMO duties and being reluctant to undertake additional clinics and operating to catch up, and also the limited availability of operating theatre time which is not already allocated for work.

	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March*
ESPI 2	17	18	18	16	40	208	73	206
ESPI 5	16	20	20	20	57	129	134	153

3.3 Coronary Angiography

There continue to be challenges for CCDHB and the central region to meet the target for elective coronary angiography to be undertaken within 90 days of a referral being accepted. The service has seen further falls in the number of patients undergoing the procedure within the 90 day target. Only 57% of procedures met this target in February. A recovery plan has been provided to the Ministry of Health which includes two additional weekly sessions and outsource of a number of these procedures to other DHBs and private providers from March 2019. All patients waiting over 120 days will be reviewed by the responsible SMO to assign a priority and identify a date for procedure, whether this is within existing capacity or through outsourcing.

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3.4 Shorter Stays in ED

During February 2019, Capital and Coast DHB achieved only 88.7 percent against the *Shorter Stays in* ED (SSiED) target of 95%. The summer months have been busier than usual with peaks in acute activity, high bed occupancy requiring the winter beds to be open, and remain open for extended periods and high levels of occupancy in ED. In early March, Wellington experienced the highest ever volume of presentations in ED.

Performance	DEC	JAN	FEB
2017-18	94%	93%	89%
2018-19	85%	89%	83%

Breaches	DEC	JAN	FEB
2017-18	327	365	533
2018-19	746	567	805

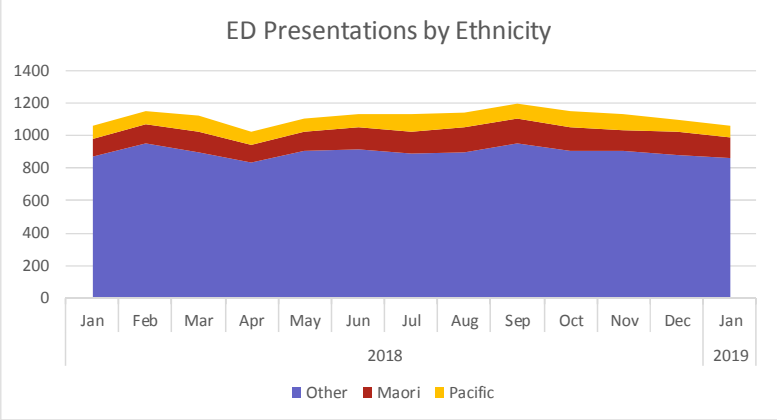
ED Volumes	DEC	JAN	FEB
2017-18	5,209	5,013	4,801
2018-19	5,059	5,015	4,721

Whilst the total presentations to ED this year are comparable to last year, the rate of admissions for February 19 is higher than the same period in the previous two years and the total adult bed occupancy (95% for Feb 19) was higher. This continues to be a significant factor affecting SSiED compliance (83% for Feb 19). Acute admissions for the whole of 2018 tracked above acute admissions for 2017, and acute admissions for January and February this year is showing equivalence to or further increases above the 2018 admission rates.

In response work continues across the hospital on improving patient flow including reducing inpatient delays to discharge, providing additional overnight capacity on IRW and opening Ward 3 (normally used to alleviate winter pressures) earlier than anticipated, early identification of patients in ED needing admissions as well as a number of other activities all designed to provide timely and appropriate inpatient interventions. The MOH SSiED Target Champion Dr Peter Jones and Carol Limber (Acute Demand Advisor) will be visiting the organisation next month at our invitation to review progress on ED patient management and help explore options opportunities to improve in-patient performance.

The service launched the 'Equity for Māori in ED' programme to coincide with Waitangi Day this year. The goal of the project is to improve the emergency department's responsiveness to the unmet needs to Māori – patients, staff and visitors – in an environment that is culturally safe for all. The project, led by Dr Jay Amaranathan, is under pinned by an ED Māori Advisory Group and a Working Group.

The graph below illustrates the ethnicity profile of patients presenting to ED by month to Jan 19.



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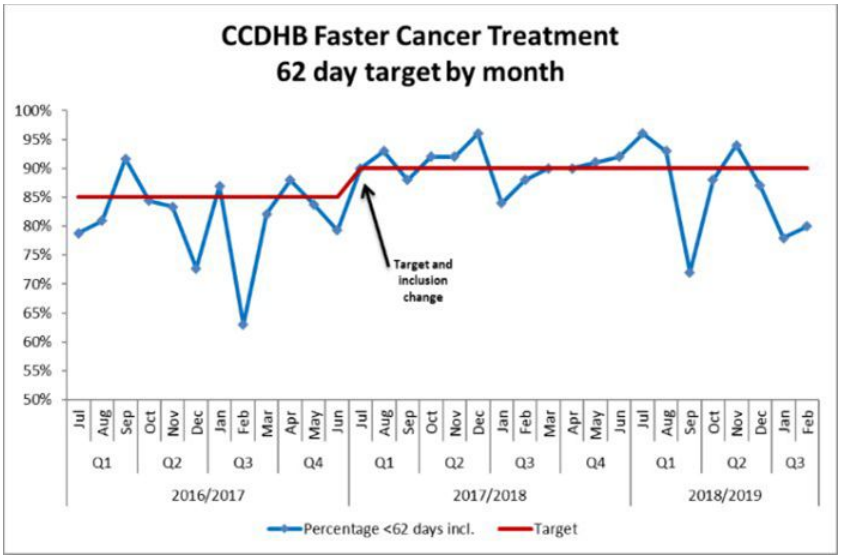
3.5 Faster Cancer Treatment

The service has seen an increase in performance from January 19 to February 19 against the Faster Cancer Treatment (FCT) target of 90% of patients receiving their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks. This accounts for 25% of all new cancer referrals. Whilst February's performance is 80%, up 2% from January, it remains behind target. Across January and February this amounted to 7 patients exceeding the 62 day target waiting time for an FSA or surgery, however 4 of those patients did so for clinical reasons.

The RDA strike action has had a significant impact on the services ability to see patients for FSAs and on the time take for making a decision to treat. Furthermore the consequence of fewer patients being seen as clinics have been cancelled due to the strike means each patient we fail to see in the appropriate timescale has an increased effect on overall percentage by which the targets are missed.



The FCT programme 31 day indicator is for all patients with a confirmed diagnosis of cancer to receive their first cancer treatment within 31 days. Across January and February 13 patients didn't get their treatment within this timeframe, with 7 of those avoidable, due to having to wait for surgery likely due to the RDA strike action.

The service is working with other services to improve the service for these patients. In particular it is working with Pathology to ensure that patient samples are appropriately prioritised, Urology to ensure cancer patients needing this service are unaffected by sabbatical arrangements, Cardiothoracic to ensure thoracic patients are prioritised and working with Respiratory to meeting diagnostic timescales.

3.6 Access to Diagnostics – Radiology

MOH Performance Indicators - CT

Performance against the CT and MRI MOH indicator for non-urgent referrals continues to be a challenge for the service. February saw an improvement on the 12 month low in January, however this is still significantly below the target of 95%. December and January figures tend to reflect a combination of reduced outpatient lists due to staff leave and hospital closures over the Christmas period which also explain the reduction in the number of outsourced scans.

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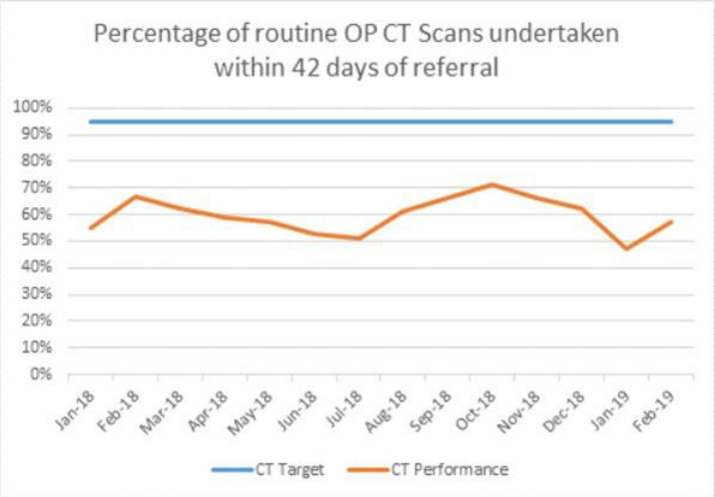
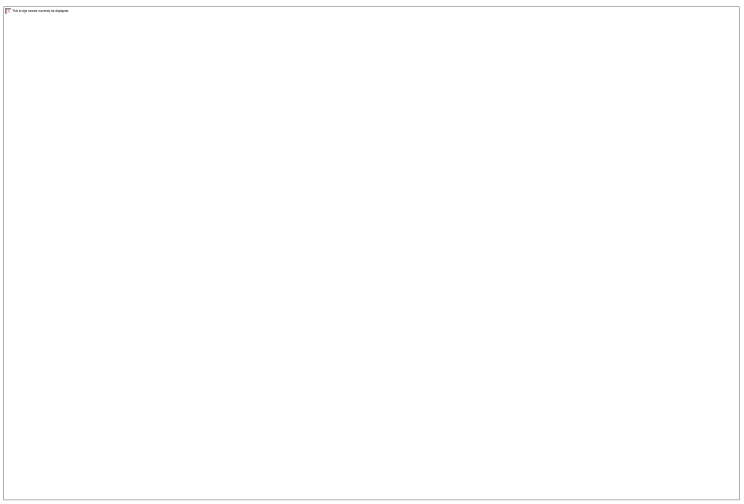


The Radiology service had planned to outsource increased numbers of CT scans in 2018/19. Unfortunately outsourcing providers were unable to provide sufficient scanning capacity to significantly reduce the number of patients waiting. Consequently the service, working with staff and unions has developed a workforce development plan which will enable the service to extend the hours across all 7 days a week. To date this the service has recruited an additional 5.0 FTE Medical Radiation Technologists (MRTs). Training of additional CT MIT's (Medical Imaging Technologists) recruited thus far began in January, with further increases in staff planned over the next few months which will allow the service to operate afterhours on weekends and/or evenings, with agreement of next year's investment proposal allowing the service to sustain the 7 day service model.

MOH Performance Indicators - MRI

Whilst the percentage of MRI scans within 6 weeks improved in the months prior to Christmas they fell over the Christmas period for reasons similar to those for CT. February registered an improvement on the January results but the percentage of scans remain significantly below the target of 90%.



The service continues to outsource scans when there is capacity and has plans to run ad hoc elective MRI lists and weekend lists as staffing allows. There is a local and national shortage of qualified staff. As part of the workforce development plan the service is increasing the number of trainees by training CT MRTs to become MRI MRTs

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Colonoscopies

The Gastroenterology service have experienced a 60% increase in endoscopy procedures over the last two years that has put significant pressure on the service. In response the service has prioritised the urgent and non-urgent colonoscopies at the expense of the surveillance colonoscopies, with the result that only 45% of surveillance colonoscopies are undertaken within 84 days against a target of 70%. However the number of urgent colonoscopies waiting less than 14 days has now dropped to 87%, below the 90% target. Non-urgent colonoscopies remains above target.

The service continues to outsource colonoscopies. An additional Gastroenterologist has recently started and will operate additional colonoscopy sessions very shortly. The service plans to develop and utilize the facilities at Kenepuru that have been earmarked for Bowel Screening, by opening this unit in December 2019, earlier than anticipated to help reduce the number of patients waiting.

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Capital & Coast District Health Board ŪPOKO KI TE URU HAUORA	**HEALTH SYSTEM COMMITTEE INFORMATION**
	Date: 13 March 2019

Author	Lisa Smith, System Development Manager
Endorsed by	Rachel Haggerty, Director, Systems Innovation and Performance
Subject	**LOCAL RESPONSE TO AN OUTBREAK OF INFLUENZA AND NOTIFICATION THERE HAVE BEEN NO CONFIRMED CASES OF MEASLES IN OUR COMMUNITY**

RECOMMENDATIONS

It is **recommended** that the Committee:

(a) **Notes** there are currently cases of H_1N_1 influenza in the Hawkes Bay and measles in Canterbury;

(b) **Notes** last week there was a local outbreak of influenza, with the majority of cases seen by Victoria University Student Health and Wellington Accident & Medical Centre. None of the cases have been identified as the H_1N_1 strain and presentations appear to be tapering off;

(c) **Notes** there have not been any confirmed cases of measles in CCDHB;

(d) **Notes** that general practice are experiencing an increase in people requesting immunisations or information about their immunisation status. Isolation protocols are being followed for anyone presenting with a high fever and/or rash.

1. PURPOSE

The purpose of this paper is to inform the Health System Committee of the local response to an influenza outbreak and that there have not been any confirmed cases of measles in our community.

This update is within the context of the H_1N_1 influenza outbreak in the Hawkes Bay and the current measles outbreak in Canterbury.

2. INFLUENZA

There has been an outbreak of influenza in CCDHB in early March. The majority of cases are people aged 17-27 years and have been seen by Victoria University Student Health Services and Wellington Accident & Medical Centre.

The outbreak began on the 1st of March and escalated over the following week, peaking on Tuesday 5th March when both services experienced high volumes of patients with flu symptoms. In response, Wellington Accident & Medical remained open until 1am – their usual closing time is 11pm. Activity appears to be tapering off now.

Both services have been supported by Regional Public Health who swabbed affected patients under RPH protocols. Of 59 swabbed cases, 41 were positive for Influenza A and the remainder were negative for influenza. Two samples have been sent for typing but results are not yet available i.e. there are no confirmed cases of H_1N_1 in CCDHB. On the advice of RPH, patients are now being swabbed only if the doctor has a specific reason to do so.

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All practices are maintaining a high level of caution with anyone presenting with flu-like symptoms. The DHB has mobilised our influenza monitoring group and, alongside our PHOs, we are monitoring cases to identify potential outbreaks early. Attached is an example of a monitoring tool used by Tū Ora Compass Health to identify surges in people presenting with influenza-like illnesses (ILI) in general practice.

A medical officer of health from RPH has also identified an outbreak in Lower Hutt at a psychogeriatric hospital and there was a cruise ship in Wellington last week which had an influenza outbreak. They also note there has been a high number of flu cases this year.

3. MEASLES

There have not been any confirmed cases of measles in CCDHB. General practices are on alert and are experiencing an increase in people requesting immunisations for themselves or their children, or requesting information about their immunisation status. Isolation protocols are being followed for anyone presenting with a high fever and/or rash.

All practices are receiving the National Health Advisories from Regional Public Health and PHOs are distributing information to staff about how to protect yourself and whānau.

APPENDIX